STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. The facility is not in substantial compliance with 42 CFR 483.73 for Long Term Care (LTC) Facilities. Census: 165	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires	E 039		1/17/25

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

Electronically Signed | 01/24/2025

1/29/25: POC accepted per Jose Gonzaelz, SSM-1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 1 activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 2 engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 3 community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 4 functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 5 functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 6 a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 7 (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 8 (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 9 maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain the Emergency Plan (EP). This was evidenced by missing documentation for an actual emergency that required activation of the EP. This could result in the facility not being prepared during an emergency. This affected 165 of 165 residents in four of four smoke compartments. Findings: During a document review and interview with the Maintenance Director (MD) on 1/14/25, the EP was reviewed. At 5:20 p.m., the after-action report was missing for an in-service conducted on 4/12/24 following an actual internal fire emergency. Upon interview, the MD stated it would be with Human Resources and does not have access to it at this time.	E 039	Complaint: E039 A) How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. We completed after action report on 4/12/2024 – Attached 2. Perform disaster drills twice per year to ensure proper safety measure with staff and residents B) How the facility will identify the residents having the potential to be affected by the deficient practice and what corrective action will be taken: 1. Performed further inspection of A/C units and rooms in building on 4/12/2024 2. Continued inspections monthly x 3 C) What measure will be put in place or what system changes will the facility make to ensure that the deficient practice does not recur: Monthly inspection by maintenance supervisor and maintenance staff will be done and report findings to Administrator D) How the facility plans to monitor its performance to make sure that solutions are sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the QA system.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 10	E 039	Maintenance Supervisor will report the findings of the Monthly inspection to the QA Committee to monitor trends This plan of corrections constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because it is required by Health and Safety Code section *** and ** CFR *** provisions. Develop EP Plan, Review and Update Annually The immediate corrective action(s) is We completed after action report on 4/12/2024 – Attached and perform disaster drills twice per year to ensure proper safety measure with staff and residents . A full inspection was performed by the Maintenance Supervisor to ensure compliance, and monthly inspections by the Maintenance Supervisor or designee will be done to ensure continued compliance. The POC is also integrated into the QA system.	
K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1989 K7 SURVEY UNDER: 2012 EXISTING	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 11 STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE V (111), FULLY SPRINKLERED. Resident Certified Beds: 178 Resident Census: 165 The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. The facility is not in substantial compliance with 42 CFR §483.90 for Long Term Care Facilities.	K 000		
K 161 SS=E	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered	K 161		1/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 12 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain the building construction. This was evidenced by several penetrations in the interior walls. This could result in the transfer of smoke throughout the compartment. This affected 119 of 165 residents in two of four smoke compartments. NFPA 101- Life Safety Code, 2012 Edition 8.5.6 Penetrations. 8.5.6.2 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling	K 161	Complaint: K161 A) How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 3. Patched hole near rooms 409 and 410 on 1/16/2025 4. Repatched ceiling hole with fire stop on 1/16/2025 5. Repaired hole and patched drywall on 1/16/2025 6. Hole in room 404 was patched and repaired 1/16/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 13 assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. Findings: During a tour of the facility and interview with the Maintenance Director on 1/14/25, the building construction was observed. 1. At 9:37 a.m., a penetration in the ceiling was approximately two inches in length and one-quarter inch width adjacent to a fire sprinkler's escutcheon plate. This was located outside the east exit door adjacent to rooms 409 and 410. Upon interview, the MD stated their last quarterly sprinkler system inspection with the vendor was in November 2024. 2. At 10:30 a.m., a penetration into the ceiling was approximately one and a half inches in length and one-quarter inches in width adjacent to telephone wiring in the telephone room south of the employee lounge. Upon interview, the MS stated the stucco separated from the ceiling. 3. At 11:12 a.m., a penetration in the northeast wall of the Nourishment Room located within Nurses Station 1 was approximately three-quarters of an inch in width by one inch in length. Upon interview, the MD stated it was the force from the door opening that created the penetration. 4. At 12:37 a.m., a penetration in the east wall approximately one-half of an inch in diameter was located in Room 404 across from the bathroom.	K 161	B) How the facility will identify the residents having the potential to be affected by the deficient practice and what corrective action will be taken: 3. Full inspection in all rooms and offices was performed by maintenance supervisor on 1/17/2025 to ensure compliance. C) What measure will be put in place or what system changes will the facility make to ensure that the deficient practice does not recur: Monthly inspection by maintenance supervisor and maintenance staff will be done and report findings to Administrator D) How the facility plans to monitor its performance to make sure that solutions are sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the QA system. Maintenance Supervisor will report the findings of the Monthly inspection to the QA Committee to monitor trends This plan of corrections constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because it is required by Health and Safety Code section *** and **	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 14 Upon interview, the MS stated a door stopper fell off there.	K 161	CFR *** provisions. Develop EP Plan, Review and Update Annually. The immediate corrective action(s) is Patched hole near rooms 409 and 410 on 1/16/2025, Repatched ceiling hole with fire stop on 1/16/2025, Repaired hole and patched drywall on 1/16/2025, and Hole in room 404 was patched and repaired 1/16/2025. A full inspection was performed by the Maintenance Supervisor to ensure compliance, and monthly inspections by the Maintenance Supervisor or designee will be done to ensure continued compliance. The POC is also integrated into the QA system.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)	K 351		1/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to maintain installation of the fire sprinkler system. This was evidenced by several escutcheon plates not covering the space between fire sprinklers. This could result in the transfer of smoke though the attic space and throughout the compartment. This affected 77 of 163 residents in two of four smoke compartments. NFPA 101: Life Safety Code, 2012 Edition 19.3.5 Extinguishment Requirements. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7.1 Automatic Sprinklers. 9.7.1.1 * Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: (1) NFPA 13, Standard for the Installation of Sprinkler Systems NFPA 13: Standard for the Installation of Sprinkler Systems, 2010 Edition 6.2.7 Escutcheons and Cover Plates. 6.2.7.1 Plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. 6.2.7.2 * Escutcheons used with recessed, flush-type, or concealed sprinklers shall be part of a listed sprinkler assembly. Findings:	K 351	Complaint: K351 A) How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 7. We corrected the escutcheon plate and put it in its proper position near room 302 on 1/16/2025 8. We corrected the escutcheon plate and put it in its proper position near room 813 on 1/16/2025 B) How the facility will identify the residents having the potential to be affected by the deficient practice and what corrective action will be taken: 4. Full inspection in all rooms and offices was performed by maintenance supervisor on 1/17/2025 to ensure compliance. C) What measure will be put in place or what system changes will the facility make to ensure that the deficient practice does not recur: Monthly inspection by maintenance supervisor and maintenance staff will be done and report findings to Administrator D) How the facility plans to monitor its performance to make sure that solutions are sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the QA system. Maintenance Supervisor will report	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 16 During a survey tour and interview with the Maintenance Director (MD) on 1/14/25, the fire sprinkler system was observed. 1. At 12:11 a.m., an escutcheon plate for a recessed fire sprinkler was not flush leaving a crescent-shaped opening into the ceiling approximately one-quarter inch in width. This was located in the Soiled Utility Room adjacent to Room 302 Upon interview, the MD stated the escutcheon plate needed to be moved into place. 2. At 2:09 p.m., an escutcheon plate for a recessed fire sprinkler was not flush leaving a crescent-shaped opening into the ceiling approximately one-half of an inch in width. This was located in Room 813. Upon interview, the MD stated the escutcheon plate needed to be moved into place.	K 351	the findings of the Monthly inspection to the QA Committee to monitor trends This plan of corrections constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because it is required by Health and Safety Code section *** and ** CFR *** provisions. Develop EP Plan, Review and Update Annually The immediate corrective action(s) is We corrected the escutcheon plate and put it in its proper position near room 302 on 1/16/2025 and We corrected the escutcheon plate and put it in its proper position near room 813 on 1/16/2025. A full inspection was performed by the Maintenance Supervisor to ensure compliance, and monthly inspections by the Maintenance Supervisor or designee will be done to ensure continued compliance. The POC is also integrated into the QA system.	
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection,	K 353		1/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 17 Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation review and interview, the facility failed to maintain the fire sprinkler system. This was evidenced by a post indicator valve without an information sign. This could result in a delay for emergency services or staff to locate the equipment in an emergency or routine maintenance. This affected 165 of 165 residents in four of four smoke compartments. NFPA 101, Life Safety Code, 2012 Edition. 19.3.5 Extinguishment Requirements. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7 Automatic Sprinklers and Other Extinguishing Equipment. 9.7.4 Manual Extinguishing Equipment. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested,	K 353	Complaint: K353 A) How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. Post indicator valve sign was ordered, received, and installed on 1/22/2025 B) How the facility will identify the residents having the potential to be affected by the deficient practice and what corrective action will be taken: 1. Monthly inspection of PIV sign to ensure compliance. C) What measure will be put in place or what system changes will the facility make to ensure that the deficient practice does not recur: Monthly inspection by maintenance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 18 and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition 4.1.8 Information Sign. 4.1.8.1 A permanently marked metal or rigid plastic information sign shall be placed at the system control riser supplying an antifreeze loop, dry system, preaction system, or auxiliary system control valve. 4.1.8.2 Each sign shall be secured with a corrosion-resistant wire, chain, or other approved means and shall indicate at least the following information: (1) Location of the area served by the system 13.3 Control Valves in Water-Based Fire Protection Systems. 13.3.2 Inspection. 13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. 13.3.2.2* The valve inspection shall verify that the valves are in the following condition: (1) In the normal open or closed position (2) *Sealed, locked, or supervised (3) Accessible (4) Provided with correct wrenches (5) Free from external leaks (6) Provided with applicable identification Findings: During a tour of the facility and interview with the Maintenance Director (MD) on 1/14/25, the fire	K 353	supervisor and maintenance staff will be done and report findings to Administrator D) How the facility plans to monitor its performance to make sure that solutions are sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the QA system. Maintenance Supervisor will report the findings of the Monthly inspection to the QA Committee to monitor trends This plan of corrections constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because it is required by Health and Safety Code section *** and ** CFR *** provisions. Develop EP Plan, Review and Update Annually The immediate corrective action(s) Post indicator valve sign was ordered, received, and installed on 1/22/2025. A full inspection was performed by the Maintenance Supervisor to ensure compliance, and monthly inspections by the Maintenance Supervisor or designee will be done to ensure continued compliance. The POC is also integrated into the QA system.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 19 sprinkler system was observed. At 10:16 p.m., the post indicator valve located southwest of the facility did not have an identification sign. Upon interview, the MD stated it was ordered last week.	K 353		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no	K 363		1/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 20 restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the corridor doors. This was evidenced by a corridor door that was propped open by an external object. This could result in a delay to contain smoke from transferring from the room to the corridor within the compartment. This affected 74 of 163 residents in one of four smoke compartments. NFPA 101- Life Safety Code, 2012 Edition 19.3.6.3 * Corridor Doors. 19.3.6.3.10 * Doors shall not be held open by devices other than those that release when the door is pushed or pulled. Findings: During a tour of the facility and interview with the Maintenance Director (MD) on 1/14/25, the corridor doors were observed. At 1:15 p.m., the corridor door to the Unit Manager's Office at Nurses Station 2 was propped open with a wedged door stopper. Upon interview, the MS stated he was unsure who put the door stopper there.	K 363	Complaint: K363 A) How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. Wedge door stopper was removed on 1/14/2025 B) How the facility will identify the residents having the potential to be affected by the deficient practice and what corrective action will be taken: 1. Inservice of staff on appropriate standard of corridor doors and blockage on 1/24/2025 C) What measure will be put in place or what system changes will the facility make to ensure that the deficient practice does not recur: Monthly inspection by maintenance supervisor and maintenance staff will be done and report findings to Administrator D) How the facility plans to monitor its performance to make sure that solutions are sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 21	K 363	is integrated into the QA system. Maintenance Supervisor will report the findings of the Monthly inspection to the QA Committee to monitor trends This plan of corrections constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because it is required by Health and Safety Code section *** and ** CFR *** provisions. Develop EP Plan, Review and Update Annually. The immediate corrective action(s) is Wedge door stopper was removed on 1/14/2025 and Inservice on 1/24/2025. A full inspection was performed by the Maintenance Supervisor to ensure compliance, and monthly inspections by the Maintenance Supervisor or designee will be done to ensure continued compliance. The POC is also integrated into the QA system.	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing	K 511		1/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 511	Continued From page 22 installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview. the facility failed to maintain the electrical utilities. This was evidenced by a several electrical appliances with tension along their power cords while plugged into an unsecured surge protector, and an electrical outlet without a listed cover plate. This could result in physical damage to the electrical equipment and igniting into an electrical fire. This affected 119 of 165 residents in two of four smoke compartments. NFPA 101: Life Safety Code, 2012 Edition 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70: National Electrical Code, 2011 Edition 406.6 Receptacle Faceplates (Cover Plates). Receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Receptacle faceplates mounted inside a box having a recess-mounted receptacle shall effectively close the opening and seat against the	K 511	Complaint: K511 A) How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 9. We secured the power strip to the wall to remove the tension on 1/14/2025 10. A new electrical outlet cover plate in room 602 was placed on 1/14/2025 B) How the facility will identify the residents having the potential to be affected by the deficient practice and what corrective action will be taken: 5. Full inspection in all rooms and offices was performed by maintenance supervisor on 1/17/2025 to ensure compliance. C) What measure will be put in place or what system changes will the facility make to ensure that the deficient practice does not recur: Monthly inspection by maintenance supervisor and maintenance staff will be done and report findings to Administrator D) How the facility plans to monitor its performance to make sure that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 511	Continued From page 23 mounting surface. 400.10 Pull at Joints and Terminals. Flexible cords and cables shall be connected to devices and to fittings so that tension is not transmitted to joints or terminals. Exception: Listed portable single-pole devices that are intended to accommodate such tension at their terminals shall be permitted to be used with single-conductor flexible cable. Informational Note: Some methods of preventing pull on a cord from being transmitted to joints or terminals are knotting the cord, winding with tape, and fittings designed for the purpose. Findings: During a tour of the facility and interview with the Maintenance Director (MD) on 1/14/25, the electrical utilities were observed. 1. At 11:44 a.m., a Keurig Coffee Maker and a Magic Chef Microwave were observed with tension in their power cords while connected to an unsecured Defiant surge protector approximately five inches above the ground. This was located in the Unit Manager's Office at Nurses Station One. Upon interview, the MD stated the Unit Manager's staff plugged those appliances in. 2. At 1:19 p.m., an electrical outlet behind the bed of resident R.G. in room 602 did not have a cover plate. Upon interview, the MS stated it broke off at some unknown time.	K 511	solutions are sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the QA system. Maintenance Supervisor will report the findings of the Monthly inspection to the QA Committee to monitor trends This plan of corrections constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because it is required by Health and Safety Code section *** and ** CFR *** provisions. Develop EP Plan, Review and Update Annually The immediate corrective action(s) is to install a new electrical outlet cover plate and secured the power strip to the wall to remove the tension on. A full inspection was performed by the Maintenance Supervisor to ensure compliance, and monthly inspections by the Maintenance Supervisor or designee will be done to ensure continued compliance. The POC is also integrated into the QA system.	
K 918 SS=C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 918		1/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 24 Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain the emergency diesel generator. This was evidenced by missing documentation of weekly visual inspections of the	K 918	Complaint: K918 A) How corrective action(s) will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 25 diesel generator and its components. This could result in the malfunction of the diesel generator during an emergency. This affected 165 of 165 residents in four of four smoke compartments. NFPA 101: Life Safety Code, 2012 Edition 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1.3 Emergency Generators and Standby Power Systems. Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2. 9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110: Standard for Emergency and Standby Power Systems, 2010 Edition 8.3 Maintenance and Operational Testing. 8.3.7* Storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.4 Operational Inspection and Testing. 8.4.1 * EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. Findings: During a document review and interview with the Maintenance Director (MD) on 1/14/25, the documents for the diesel generator were reviewed.	K 918	accomplished for those residents found to have been affected by the deficient practice: 1. Inservice maintenance staff on proper documentation of generator maintenance 1/24/2025 B) How the facility will identify the residents having the potential to be affected by the deficient practice and what corrective action will be taken: 1. Inservice maintenance staff on proper documentation of generator maintenance 1/24/2025 C) What measure will be put in place or what system changes will the facility make to ensure that the deficient practice does not recur: Tels put in place to ensure proper documentation on weekly basis. D) How the facility plans to monitor its performance to make sure that solutions are sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the QA system. Maintenance Supervisor will report the findings of the Monthly inspection to the QA Committee to monitor trends This plan of corrections constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 26 At 3:55 p.m., the Weekly/Monthly Generator logs documents were missing 1 of 52 weeks of documented visual inspections. Upon Interview, the MD stated his staff documented the inspection but did not transfer the data onto the permanent logs afterwards.	K 918	This plan of correction is prepared and/or executed solely because it is required by Health and Safety Code section *** and ** CFR *** provisions. Develop EP Plan, Review and Update Annually. The immediate corrective action(s) is Inservice maintenance staff on proper documentation of generator maintenance 1/24/2025. The POC is also integrated into the QA system.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room,	K 923		1/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 27 where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the storage of gas cylinder storage. This was evidenced by several unsecured oxygen cylinders in the resident's rooms. This could result in physical damage to the cylinders releasing oxidizing gases throughout the affected rooms. This affected 2 of 165 residents in one of four smoke compartments. NFPA 99: Health Care Facilities Code, 2012 Edition 11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures: (1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device. (2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them. (3) Cylinders shall be protected from tampering by unauthorized individuals. (4) Cylinders or cylinder valves shall not be repaired, painted, or altered.	K 923	Complaint: K923 A) How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. Room 116 oxygen tank removed and placed into proper outside storage 1/14/2025 2. Room 203 oxygen tanks removed and placed into proper outside storage 1/14/2025 B) How the facility will identify the residents having the potential to be affected by the deficient practice and what corrective action will be taken: Full inspection in all rooms was performed by maintenance supervisor on 1/17/2025 to ensure compliance. C) What measure will be put in place or what system changes will the facility make to ensure that the deficient practice does not recur:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 28 (5) Safety relief devices in valves or cylinders shall not be tampered with. (8) Sparks and flame shall be kept away from cylinders. (9) Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them. (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. (12) Cylinders shall not be supported by radiators, steam pipes, or heat ducts Findings: During a tour of the facility and interview with the Maintenance Director (MD) on 1/14/25, the storage of gas cylinders was observed. 1. At 10:52 a.m., one E-type oxygen cylinder was unsecured in the northwest corner of Room 116. Upon interview, the MS stated it was put there after their therapy was completed. 2. At 11:35 a.m., one of two E-type oxygen cylinders was unsecured in the closet of Room 203. Upon interview, the MS stated they have some of these old cylinders around that were not picked up by their vendor.	K 923	Monthly inspection by maintenance supervisor and maintenance staff will be done and report findings to Administrator. D) How the facility plans to monitor its performance to make sure that solutions are sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the QA system. Maintenance Supervisor will report the findings of the Monthly inspection to the QA Committee to monitor trends This plan of corrections constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because it is required by Health and Safety Code section *** and ** CFR *** provisions. Develop EP Plan, Review and Update Annually. The immediate corrective action(s) is Room 116 oxygen tank removed and placed into proper outside storage 1/14/2025 Room 203 oxygen tanks removed and placed into proper outside storage 1/14/2025. A full inspection was performed by the Maintenance Supervisor to ensure compliance, and monthly inspections by the Maintenance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. BUILDING **02** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS POST ACUTE	**74-350 COUNTRY CLUB DRIVE** **PALM DESERT, CA 92260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 29	K 923	Supervisor or designee will be done to ensure continued compliance. The POC is also integrated into the QA system.	