PRINTED: 06/08/2022 FORM APPROVED OMB NO. 0938-0391

## Special Control of the Provider or Supplier AME OF PROVIDER OR SUPPLIER	TEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE COMP	LETED
AME OF PROVIDER OR SUPPLIER IANORCARE HEALTH SERVICES-PALM DESERT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL FREGULATORY OR LSC IDENTIFYING INFORMATION) FREGULATORY OR LSC IDENTIFYING INFORMATION) FOOD FREET AND DESERT, CA 92260 FREDOUBERS PLAN OF CORRECTION FREGULATORY OR LSC IDENTIFYING INFORMATION) FOOD FREED CASS-REFERENCED TO THE APPROPRIATE FROM DESTRUCTORY OF A 12 APPROPRIATE The statements made in this Plan of Correction are not an admission to or an agreement with the stated deficiencies are deficiencies. To remain in compliance with all Federal and State Regulations, the facility's A 1 Readility and Excess of A 12 APPROPRIATE FOOD FREED CASC APPROPRIATE FROM DESTRUCTORY OF A 12 APPROPRIATE The statements made in this Plan of Correction To The Appropriate with the stated deficiencies are a 12 APPROPRIATE FROM DESTRUCTORY OF A 12 APPROPRIATE FROM DESTRUCTORY OF A 12 APPROPRIATE The statements made in this Plan of Correction To The AP	D PLAN OF	CORRECTION	DENTI TOTALOR TELEPO	A. DUILDI		1	
The statements made in this Plan of Correction are not an admission to or an agreement with the stated deficiencies. To remain in compliance with all stated deficiencies have been or will be corrected by the specific date/s. Food The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. Shall (2)(1)(2)(2)(1)(1)(2) Shall (2)(1)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)			555339	B, WING			3/2022
The following reflects the findings of the California Department of Public Health during the investigation of two linked complaint. Complaint Numbers: CA00783019 linked with CA00782801. Representing the Department: Health Facilities Evaluator Nurse: 41348 The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. Five deficiencies were identified for the complaint numbers: CA00783019 linked with CA00782801. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) \$483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. \$483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	PREF	74-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260 PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	CORRECTION ION SHOULD BE THE APPROPRIATE	COMPLETION
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	F 550 SS=D	The following reflicalifornia Departminvestigation of two Complaint Number CA00782801. Representing the Health Facilities Experience of the Health Facilities Experience of the findings of a few complaints invest the finding few complete the facility of the facility of the facility of the few complete the findividuality. The promote the right format in a map format few complete few comp	ects the findings of the nent of Public Health during the o linked complaint. ers: CA00783019 linked with Department: Evaluator Nurse: as limited to the specific tigated and does not represent full inspection of the facility. were identified for the complain (83019 linked with CA00782801) Exercise of Rights (a)(1)(2)(b)(1)(2) dent Rights. (a) a right to a dignified existence, on, and communication with and ty, including those specified in facility must treat each resident of dignity and care for each tenner and in an environment that the enance or enhancement of his complete in the resident.	t t or	The statements made Correction are not a or an agreement with deficiencies. To remain in complification of Correction constituted and State Responsible of Correction constituted allegation of Compall stated deficience will be corrected by date/s. F550 It is the practice of patients with dign. A) Patient 1 in the facility. B) This practice of potential to affect on suicide preventable facility wide associated preventable facility with the facility wide associated preventable facility wide associated preventable facility	iance with all egulations, the will take the following This Plan of tes the facility's pliance such that ies have been or y the specified If this facility treat ity and respect. In longer resides tice has the patients who are a plastic any other g plastic	(X6) DATE

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.

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	UPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ON NUMBER: A. BUILDING				TE SURVEY MPLETED
		555339	B. WING	à		1	С
NAME OF	PROVIDER OR SUPPLIER		D. WINTO		STREET ADDRESS, CITY, STATE, ZIP CODE	06/	03/2022
MANOR	CARE HEALTH SERVI	CES-PALM DESERT		7	74-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BF	(X5) COMPLETION DATE
	access to quality ca severity of condition must establish and practices regarding provision of services residents regardless §483.10(b) Exercise The resident has the rights as a resident or resident of the Ur §483.10(b)(1) The fa- resident can exercis interference, coercio from the facility. §483.10(b)(2) The re- free of interference, reprisal from the faci- rights and to be supp- exercise of his or hel- subpart. This REQUIREMENT by: Based on interview a failed to ensure the re- dignity and respect, for reviewed (Resident 1 given plastic utensils period of time. This failure increased affect Resident 1's pse- Findings:	acility must provide equal re regardless of diagnosis, or payment source. A facility maintain identical policies and transfer, discharge, and the sunder the State plan for all sof payment source. To Rights. To right to exercise his or her of the facility and as a citizen	F 5	550	C) In-service was prese Staff by the Administrator/ Eregarding use of plastic silve on 5.25.22-5.26.22 and 6.14. D) Compliance will be monitored by tray line audits completed by the food service director 3 x week for 4 week monthly x 2 months. Finding be presented monthly to Quan Assurance Performance Improvement committee for purpose of analyzing and identifying trends, and to mo for compliance and make recommendations.	osD rware 2022 se s then gs will lity	4/20/22

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING		ATE SURVEY DMPLETED
		555339	B. WING	· · · · · · · · · · · · · · · · · · ·		С
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-PALM DESERT		STREET ADDRESS, CITY, STATE, ZIP OF 74-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260	CODE	6/03/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
	complaint which ind provided regular ute days before discharher hands. On May 6, 2022, at interview was conducted resident 1 stated who staff "What do I haround here? Slit mythe facility put her or her a plastic spoon to she did not receive so (May 5) and that she just a plastic spoon at visit was conducted investigation of the at On May 10, 2022, at visit was conducted investigation of the at On May 10, 2022, with surgical aftercare right (high blood pressure). Resident 1's physicial indicated Resident 1 decisions. The record further incomplete the plastic utensils x (time plastic utensils x (time plastic utensils x (time).	icated Resident 1 was not ensils to eat with until a few ge and she had to eat with 10:10 a.m., a telephone ected with Resident 1. In hile at the facility she stated ave to do to get service of wrists?" Resident 1 stated in suicide watch and only gave of eat with. Resident 1 stated is liverware until yesterday is had to eat her meals with eand her "dirty hands." 10:40 a.m., an unannounced at the facility for the bove complaint. Pesident 1's record was was admitted to the facility in diagnoses which included that knee, and hypertension had capacity to make dicated that Resident 1 was 122. Is "Behavioral Symptoms and physical size and instructed no silverware, ideation: "slit her wrist and instructed no silverware,	F 5	50		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY MPLETED
		555339	B. WING			1	C /03/2022
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-PALM DESERT		74-3	EET ADDRESS, CITY, STATE, ZIP CODE 50 COUNTRY CLUB DRIVE	1 00/	03/2022
				PAL	.M DESERT, CA 92260		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	20, 2022, at 11:44 a re-assessed for BIN status) with score or impairment. SS (so due to suicidal ideal self," patient confirm has a sitter at bedsi instructed plastic utility. Review of Resident 4, 2022, at 12:03 p. has regular utensils helped" Further review of Resident date Resident 1's situse. On May 10, 2022, at 11:44 are review of Resident 1's situse.	ge 3 I.m., indicated, "Patient IS (brief interview for mental of 13/15 indicating no cognitive cial service) visited patient tions, "slit wrist and harm as no plans to hurt self, now de for safety x 4 days, staff ensils for safety x 4 days" 1's progress note dated May m., indicated, "Patient also restored and states that has esident 1's record failed to fon that indicated the exact liverware was restored for her the 2:30 p.m., an interview was Administrator (Adm). The Adm	F 5	50			
	stated when a reside themselves the physical resident will be placed 1:1 sitter. The Admic sent out for evaluating The Admistated Resoriented. She stated her wrists but it was true suicidal attempts staff to not give Resoriented to a stated Residen 4 days and had a 1:1 should have had his he was off suicide with the State of the	ent threatens to hurt sician is notified and the ed a on suicide watch with a continued, the resident will be on if the physician orders it. sident 1 was alert and Resident 1 threatened to slit more for "attention" than a . The Adm stated she told ident 1 a knife for 4 days. The t 1 was on suicide watch for I sitter. She stated Resident er silverware returned after					

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION		E SURVEY IPLETED
		555339	B. WING				C /03/2022
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-PALM DESERT		7	TREET ADDRESS, CITY, STATE, ZIP CODE 4-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260	1 00/	03/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	that Resident 1 threstated she did not be suicidal, but "acting stated Resident 1 with staff was told to not concurrent record roon the behavioral neutensil for 4 days. Show it got input as present the stated Resident would be very difficult plastic knife, and shone. The SSC stated Resident 1's 1:1 sittle there was no order plastic utensils. She documentation whe silverware back. The which indicated Resident 4, 2022, almost have gotten her silversident silversilve	ratened to slit her wrists. She believe Resident 1 was truly out" for attention. The SSC was ordered a 1:1 sitter, and give her any knives. During a seview, the SSC stated based once it was changed to plastic the stated she was not sure plastic utensils for 4 days. The note 1 had a 1:1 sitter and it will to cause actual harm with a se should have been provided do the physician extended er until April 25, 2022 but for note to continue with the estated there was no in Resident 1 received her se SSC stated the first note sident 1 had silverware was to two weeks after she should be and only having plastic	F 5	550			
	concurrent record red Director of Nursing progress note dated indicated Resident and harm herself. Tindicated a 1:1 sitted days. She stated Reregular silverware b DON stated there we utensils but could har judgement. The DO determined Resider watch, her silverware	t 2:52 p.m., an interview and eview were conducted with the (DON). The DON stated the April 20, 2022, at 11:44 a.m., I threatened to slit her wrist he DON stated the note and plastic utensils for 4 esident 1 should have gotten ack on April 24, 2022. The as no order for the plastic ave been a nursing N stated when it was at 1 was no longer on suicide e should have been returned.					

TATEMENT	OF DEFICIENCIES F CORRECTION				CONSTRUCTION	COMP	LETED
		555339	B. WING			06/0	3/2022
	PROVIDER OR SUPPLIER	ICES-PALM DESERT		74-3	EET ADDRESS, CITY, STATE, ZIP CODE 350 COUNTRY CLUB DRIVE LM DESERT, CA 92260		(VE)
(X4) ID PREFIX TAG	(CACH DEEICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETION DATE
F 658 SS=E	had silverware was stated it was a dig silverware to eat was a dig silverware dig services provided of CFR(s): 483.21(b) (3) Constant of the services provided of the services provided by the mustification of the services provided of the services provide	s on May 4, 2022. The DON nity issue to not have with. titled "Resident Bill of Rights," d., "Patients have the rights is section and the facility shall rights are not violatedTo be deration, respect and full nity and individuality" d Meet Professional Standards (3)(i) Imprehensive Care Plans wided or arranged by the facility, is comprehensive care plan, and standards of quality. ENT is not met as evidenced ew and record review, the facility for one of five residents reviewed fessional standards of practice men there was no documentation evaluation of Resident 1, when on suicide watch from April and the potential to negatively 1's care and overall physical and	F	658	F658 It is the practice of this fact document on changes of co. A) Patient 1 no longer in the facility. B) This practice has the potential to affect patients experiencing changes of co. Audit was completed to id.	r resides he who are ondition.	6/20/22

	S FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_		С	A CONTRACTOR OF THE CONTRACTOR	
		555339	B. WING				3/2022	
	ROVIDER OR SUPPLIER	ICES-PALM DESERT		ST 74	REET ADDRESS, CITY, STATE, ZIP CODE 1-350 COUNTRY CLUB DRIVE ALM DESERT, CA 92260			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREF	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIES	D BE	(X5) COMPLETION DATE	
PREFIX TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)			
F 658	Continued From p	age 6	F	658				
	reviewed. Resider on April 13, 2022, surgical aftercare (high blood pressu	Resident 1's record was at 1 was admitted to the facility with diagnoses which included right knee, and hypertension ure). ician history and physical at 1 had capacity to make			any potentially unidentific of condition. MD and RP and orders/interventions v implemented if any identi- C) In-service was pr Staff by the DSD regardicharting on 5.24.2022	were ified.	6/20/22	
	Record review indischarged May 7 Review of Reside Assessment," daindicated, "Suidharm herself" Review of Reside 20, 2022, at 11:4 re-assessed for I status) with score impairment. SS (due to suicidal idself," patient conhas a sitter at be	ent 1's "Behavioral Symptoms ted April 20, 2022, at 11:04 a.m., idal ideation: "slit her wrist and ent 1's progress note dated April 4 a.m., indicated, "Patient BIMS (brief interview for mental e of 13/15 indicating no cognitive social service) visited patient leations, "slit wrist and harm firms no plans to hurt self, now edside for safety x 4 days"			D) Compliance will monitored by Unit mana auditing 24 hour commux week for 4 weeks then 2 months. Findings will presented monthly to Quasurance Performance Improvement committee purpose of analyzing an identifying trends, and the for compliance and make recommendations.	gers by nication 3 monthly be nality e for the d o monitor	X	
	documentation t evaluation of Re Resident 1 was 20-24, 2022. On May 10, 202 conducted with stated when a re	hat indicated any monitoring or sident 1 was conducted while on suicide watch from April 2, at 2:30 p.m., an interview was the Administrator (Adm). The Adesident threatens to hurt physician is notified and the placed a on suicide watch with a	m				eet Page 7 0	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		ATE SURVEY DMPLETED
		555339	B. WING			C
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP		6/03/2022
MANOR	CARE HEALTH SERV	ICES-PALM DESERT		74-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 658	1:1 sitter. The Adm sent out for evaluated The Adm stated Recoriented. She state her wrists but it was true suicidal attempton May 10, 2022, a concurrent record in Director of Nursing progress note dated indicated Resident and harm herself. Tindicated a 1:1 sitted days. She stated Remonitored while on documentation should be a concurrent record in the review of the Vocadated July 31, 2015 Vocational Nursing vocational nurse per state of the sent the review of the Vocadated July 31, 2015 Vocational nurse per state of the vocadated per sent the review of the Vocadated July 31, 2015 Vocational nurse per state of the vocadated per sent the review of the Vocadated July 31, 2015 Vocational nurse per sent the vocadated per sent the	continued, the resident will be ion if the physician orders it. I sident 1 was alert and desident 1 threatened to slit is more for "attention" than a bit. At 2:52 p.m., an interview and eview was conducted with the (DON). The DON stated the did April 20, 2022, at 11:44 a.m., 1 threatened to slit her wrist the DON stated the note or and plastic utensils for 4 esident 1 should have suicide watch and all have been done. Attional Nursing Practice Act indicated, "Scope of Practice: The licensed of the skills which include the	F 6	58		
	planning, executes with the care plan of contributes to evaluate interventions related plan. (b) Provides distributes as defined Administers medical communication skill patient/client care at Contributes to the distributes for the patient patient patient of a self-care for the patient with the care plan in the	s for the purpose of and education; and (4)				

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		555339	B. WING			С
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-PALM DESERT		STREET ADDRESS, CITY, STATE, ZIP CODE 74-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260] 06.	/03/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO	TRE	(X5) COMPLETION DATE
F 676	patients'/clients' hea include but are not I Documenting patien with standards of the	nurse shall safeguard alth and safety by actions that imited to the following:(2) t/client care in accordance e profession" g (ADLs)/Mntn Abilities	F 6	F676	y to	6/20/22
	§483.24(a) Based or assessment of a respective resident's needs and provide the necessal ensure that a resider daily living do not directly of the individual's clirated that such diminution includes the facility estable facility to carry living, including those of this section §483.24(b) Activities The facility must provaccordance with para activities of daily living \$483.24(b)(1) Hygien grooming, and oral cas \$483.24(b)(2) Mobility including walking,	the comprehensive ident and consistent with the dichoices, the facility must ry care and services to not's abilities in activities of minish unless circumstances nical condition demonstrate was unavoidable. This ensuring that: Ident is given the appropriate es to maintain or improve his out the activities of daily especified in paragraph (b) of daily living. Fide care and services in agraph (a) for the following g: e -bathing, dressing, are, Internal for ambulation,		A) Patient 1 no longer resin the facility. B) This practice has the potential to affect patients who need assistance with ADL care showers. Audit conducted, any not given shower on scheduled days in the last week was offer shower. C) In-service was present Staff by the DSD regarding showers and documentation or 5.24.2022-5.26.2022 D) Compliance will be monitored by Medical records auditing CNA charting 3 x weed 4 weeks then monthly x 2 mon Findings will be presented mor to Quality Assurance Performant Improvement committee for the purpose of analyzing and identifying trends, and to monit for compliance and make recommendations	by ek for ths.	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	C	(X3) DATE SURVEY COMPLETED	
		555339	B. WING				03/2022
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-PALM DESERT		STREET ADDRESS, CITY, STATE, ZI 74-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260	P CODE	001	0012022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD BI		(X5) COMPLETION DATE
F 676	snacks, §483.24(b)(5) Comic (i) Speech, (ii) Language, (iii) Other functional This REQUIREMEN by: Based on interview failed to provide cardaily living (ADLs) foresidents (Resident residents failed to reas scheduled. This failure had the the resident's physic well-being. On April 29, 2022, the complaint that indicate shower" while at the received another cowhich indicated Resishower while at the On May 10, 2022, a visit was conducted investigation of the I On May 10, 2022, Reviewed. Resident on April 13, 2022, wi surgical aftercare rig (high blood pressure May 7, 2022. Review of Resident	communication systems. IT is not met as evidenced and record review, the facility re and services for activities of or four of five sampled 1, 2, 3, and 4), when the receive showers and/or baths potential to negatively affect cal and psychosocial The department received a refacility. The department mplaint on May 2, 2022, sident 1 had not received a	F 6	76			

PRINTED: 06/08/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT ND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	L ` '		E CONSTRUCTION	COMP	PLETED
		555339	B. WING	-			3/2022
	PROVIDER OR SUPPLIER	CES-PALM DESERT		7.	TREET ADDRESS, CITY, STATE, ZIP CODE 4-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 676	Review of Residen Shower/Bath: Mondo Days" indicated FApril 25, 2022, and have a bath or shower/Bath: Wed 30 Days" indicated 2022. Review of Residen Shower/Bath: PRN Days" indicated, May 3, and May 5. Per facility docume one bed bath and from April 13, 2022. On May 10, 2022, reviewed. Residen on April 19, 2022, urinary tract infect April 28, 2022. Review of Resider Shower/Bath: Tue Days" indicated 2022, to have a bath Review of Resider Shower/Bath: Frid Shower	had a "wonderful shower" and was feeling much better" It 1's facility document, "Task: day EveningsLook Back 30 Resident 1 had a bed bath on refused on May 2, 2022 to wer. It 1's facility document, "Task: lnesday EveningsLook Back ed, "Not applicable" on May 4, at 1's facility document, "Task: I (as needed)Look Back 30 Resident 1 received a shower entation, Resident 1 received a shower entation, Resident 1 received two showers while at the facility 2 to May 7, 2022. Resident 2's record was at 2 was admitted to the facility with diagnoses which included ion. Resident 2 was discharged at 2's facility document, "Task: sday EveningsLook Back 30 Resident 2 refused on April 19,		376			

Facility ID: CA240000634

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	C C		
		555339	B. WING	_	REET ADDRESS, CITY, STATE, ZIP CODE	06/	03/2022	
	PROVIDER OR SUPPLIER	ICES-PALM DESERT		74	-350 COUNTRY CLUB DRIVE LLM DESERT, CA 92260			
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE	
F 676	Continued From portion one shower while 2022, to April 28, 2022, to April 28, 2022, reviewed. Resider on February 16, 22022, with diagnor fibrillation (afib-irrestenosis (narrowing cause pressure of the continuation of the con	age 11 entation, Resident 2 received at the facility from April 19, 2022. Resident 3's record was at 3 was admitted to the facility 022, and readmitted on April 4, ses which included atrial egular heart rhythm), and spinal ago of the spinal canal which can at 11:25 a.m., Resident 3 was bed. During a concurrent at 3 stated she received a y" (May 9, 2022). Ent 3's facility document, "Task and a bed bath on a shower on May 9, 2022. Ent 3's facility document, "Task ard a stated on May 9, 2022. Ent 3's facility document, "Task ard a shower on May 9, 2022. Ent 3's facility document, "Task ard a stated on May 5, ath or shower. Ent 3's facility document, "Task ard a stated on May 5, ath or shower. Ent 3's facility document, "Task ard 3's facility document, ".		676	DEFICIENCY)			
	reviewed Resid	, 2022. 2, Resident 4's record was ent 4 was admitted to the facility 2, with diagnoses which included	,					

	TEMENT OF DEFICIENCIES O PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		C C		
		555339	B. WING				03/2022
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-PALM DESERT				7	STREET ADDRESS, CITY, STATE, ZIP CODE 74-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260	1. 00/	00/2022
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE	
F 676	device that delivers to regulate the rhyth or regulate the rhyth on May 10, 2022, is sitting in a wheelch concurrent interviews shower two times a was yesterday (May Review of Resident Shower/Bath: Wed 30 Days" indicated April 20, 2022. Review of Resident Shower/Bath: Saturd Days" indicated April 16, and 23, 200 Per facility docume three showers, from 2022. On May 10, 2022, a conducted with the The DON stated rebed bath two times Certified Nursing Atthe tasks; shower, refused. The DON refused a shower the when the resident of charge nurse.	d pacemaker (a medical electric impulses to the heart nm). Resident 4 was observed air beside her bed. During a w Resident 4 stated she got a week, and her last shower y 9). 4 's facility document, "Task: nesday EveningsLook Back and Resident 4 had a shower on the task of t	F6	376			
	with CNA 1. CNA 1	stated residents received a two times a week per					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
	555339		B. WING		С		
NAME	OF PROVIDER OR SUPPLIER		10.11110	STREET ADDRESS, CITY, STATE, ZIP CODE	06/03	3/2022	
MANO	PRCARE HEALTH SERVI			74-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260			
(X4) I PREF TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	(DBE C	(X5) COMPLETION DATE	
F 69 SS=	On May 10, 2022, a interview and concuconducted with the Resident 1 had two one bed bath while Resident 2's only do 2022. The DON star shower and one bed past 30 days. The D documentation indicture showers the p the residents did not baths as scheduled. Review of the facility revised July 2016, in cleanse skin and procirculationDocume Pain Management CFR(s): 483.25(k) §483.25(k) Pain Mar The facility must ensprovided to residents consistent with profethe comprehensive pand the residents' go This REQUIREMEN' by: Based on interview, facility failed to ensure offered and/or provider reviewed (Resident 1). This failure had the phave increased pain	at 2:52 p.m., a follow up alterent record review were DON. The DON stated documented showers and at the facility. The DON stated ocumented bath was April 22, ted Resident 3 had one dis bath documented for the DON stated Resident 4's stated Resident 4 received ast 30 days. The DON stated to receive showers or bed at receive showers or bed at receive showers or bed as the company of the policy titled, "Bathing," adicated, "Purpose: To comote entCare provided" The provided of practice, person-centered care plan, and preferences. The policy is not met as evidenced and record review, the repain medication was ed for one of five residents	F6	676	ty to	2(20/2	
	This REQUIREMENT by: Based on interview, facility failed to ensure offered and/or provide reviewed (Resident 1) This failure had the p	T is not met as evidenced and record review, the re pain medication was ed for one of five residents).		,	esides		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED
	5562			MING			С
		555339	B. WING			06/	03/2022
	PROVIDER OR SUPPLIER CARE HEALTH SERV	CES-PALM DESERT		74	TREET ADDRESS, CITY, STATE, ZIP CODE 4-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From particles Findings: On May 6, 2022, at interview was conducted watch staff Tylenol for her pain. On May 10, 2022, a visit was conducted investigation of the conducted investigation of the surgical aftercare rig (high blood pressure Resident 1's physici indicated Resident of decisions. Record review indicated investigations. Review of Resident indicated; -April 13, 2022, "A	ge 14 10:10, a.m., a telephone ucted with Resident 1. while at the facility her pain was stated while she was on f did not give her anything but to 10:40 a.m., an unannounced at the facility for the above complaint. Resident 1's record was 1 was admitted to the facility ith diagnoses which included ght knee, and hypertension e). an history and physical had capacity to make			CROSS-REFERENCED TO THE APPROPE	ne who was vas being ged notified ented to pain	g Lalulu
	-April 13, 2022, "O to treat moderate to Give 1 tablet by mou for mild or moderate	rs as needed for pain" xycodone HCL (narcotic used severe pain) Tablet 5 MG ath every 6 hours as needed pain (1- 6 scale [pain scale 1 evere pain]Oxycodone HCL					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING			E SURVEY PLETED	
			, a boile	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		С		
		555339	B. WING			06/03/2022		
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MANOR	CARE HEALTH SERVI	CES-PALM DESERT			4-350 COUNTRY CLUB DRIVE			
				Р	PALM DESERT, CA 92260			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 697	Continued From pa	ge 15	F6	897				
		tablets by mouth every 6 r severe pain" Discontinued						
	Tablet Give 1000 m needed for pain ma	cating "Acetaminophen g by mouth every 8 hours as nagement NTE (not to)/APAP (acetaminophen) 24						
	moderate to severe (HYDROmorphone	Dilaudid (Narcotic used to treat pain) Tablet 2 MG HCL) Give 1 tablet by mouth reded for Pain" discontinued						
	-April 20, 2022, "S time only until 4/24/	Sitter x4 (times four) days one 22"						
	-April 22, 2022, "C 4/25/22"	Continue sitter until Monday						
	MG (HYDROcodone	orco (narcotic) Tablet 5-325 e-Acetaminophen) Give 1 ry 6 hours for pain for 2 d April 26, 2022.						
		lorco Tablet 5-325 MG etaminophen) Give 1 Tablet eded for pain"						
	2022, indicated, "F evidenced by verbal recent surgeryGoa	1's care plan dated April 14, FocusPain R (right) knee lization of pain related to alReduce episodes of InterventionsAdminister physician orders"						
	Review of Resident	1's progress note dated April						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
	555339		B. WING			C 06/03/2022		
		33333	10	_		06/	03/2022	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
MANORO	NADE HEALTH CEDV	ICES DALM DESERT		7	74-350 COUNTRY CLUB DRIVE			
MANORCARE HEALTH SERVICES-PALM DESERT			- 1	PALM DESERT, CA 92260				
(X4) ID PREFIX TAG			ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		BE	(X5) COMPLETION DATE	
	Continued From partial 14, 2022, at 4 p.m. todaypatient report to knee and curren non-effective" Review of Resident Assessment," date indicated, "Suicid harm herself"Starplastic utensils x (till Review of Resident 20, 2022, at 11:44 are-assessed for Blf status) with score of impairment. SS (so due to suicidal idea self," patient confirm has a sitter at beds Review of Resident 24, 2022, at 1:49 aphone call from patient for Norco" Review of Resident administration recompliant regimenpatient for Norco"	age 16 , indicated, "met with patient orts having severed (sic) pain t medication being It 1's "Behavioral Symptoms d April 20, 2022, at 11:04 a.m., lal ideation: "slit her wrist and ff instructed no silverware, imes) 4 days" It 1's progress note dated April a.m., indicated, "Patient MS (brief interview for mental of 13/15 indicating no cognitive ocial service) visited patient ations, "slit wrist and harm ms no plans to hurt self, now side for safety x 4 days" It 1's progress note dated April .m., indicated, "Received a tient's daughter in regards to ent stated the medication was at 3:37 p.m., "Called oncall regarding pain med new order to 1's electronic medication and (eMAR) during Resident 1's m April 20-24, 2022, indicated, ag was given twice; on April 20,		_	CROSS-REFERENCED TO THE APPROP DEFICIENCY)			
	pain scale 7. Aceta four times; on April April 23, for a pain for pain scale 7 and	e 3, and on April 22, 2022, for minophen 1000 mg was given 22, 2022, for pain scale of 4, scale of 4, and April 24, twice d 5. at 2:52 p.m., an interview and						
	OIT May 10, 2022, 8	at 2.02 parts, art interview and						

PRINTED: 06/08/2022 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION C 06/03/2022 B. WING 555339 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74-350 COUNTRY CLUB DRIVE MANORCARE HEALTH SERVICES-PALM DESERT PALM DESERT, CA 92260 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG DEFICIENCY) TAG F 697 Continued From page 17 concurrent record review were conducted with the Director of Nursing (DON). The DON stated Resident 1 was on suicide watch from April 20-24, 2022, for threats that she was going to slit her wrists. She stated Resident 1's Dilaudid was discontinued April 22, 2022, and Norco was ordered on April 24, 2022. The DON stated Resident 1 had acetaminophen for pain between April 22 and April 25, 2022. She stated she was not sure why Resident 1 went from Dilaudid, a very powerful narcotic to acetaminophen. The DON stated there should not be a hold on pain medication when someone was on suicide watch, given the licensed nurses were the ones dispensing the medication. She stated changing from Dilaudid to acetaminophen was a drastic change in pain medication. The DON stated there was no reason to withhold Resident 1's pain medication while she was on suicide watch. The DON stated Resident 1 was ordered Norco on April 24, 2022, when Resident 1 came off her suicide watch. Review of the facility policy titled, "Pain Management Guidelines," dated November 2021, indicated, "...Purpose: To describe the process steps required for interventions to prevent and or manage both acute and chronic pain...Pain-an unpleasant sensory and emotional experience associated with actual or potential damage...Patients are asked to choose a number 0 (indicating no pain) to 10 (indicating worst pain

adjustment...'

SS=D

imaginable)...pain scores of 4-7 twice in a seven-day period or those who have a single score of 8, 9 or 10 are: Reported to the medical practitioner for consideration of treatment

F 842 Resident Records - Identifiable Information

F 842

THE PERSON NAMED IN

PRINTED: 06/08/2022 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE &		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUl	TIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION					A. BUILDING			
						06/0	3/2022	
		555339	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	1 0010		
NAME OF F	ROVIDER OR SUPPLIER				-350 COUNTRY CLUB DRIVE			
MANORO	ARE HEALTH SERV	ICES-PALM DESERT			ALM DESERT, CA 92260		(VE)	
(X4) ID PREFIX TAG	VENCH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE	
				2.10				
F 842	§483.20(f)(5) Resident-identifiable (ii) The facility may not resident-identifiable accordance with a agrees not to use except to the extent to do so. §483.70(i) Medical §483.70(i)(1) In a professional stan must maintain must must must must must must must must	ident-identifiable information. of release information that is le to the public. y release information that is le to an agent only in a contract under which the agent or disclose the information ent the facility itself is permitted al records. accordance with accepted dards and practices, the facility edical records on each resident cumented; ssible; and ly organized e facility must keep confidential ontained in the resident's records a form or storage method of the when release is- ual, or their resident there permitted by applicable law aw:		842	F842 It is the practice of this figive and document show A) Patient 1 no longer in the facility. B) This practice has the potential to affect patients we need assistance with ADL conshowers. Audit conducted, a not given shower on schedul days in the last week was of shower. C) In-service was presserated by the DSD regarding showers and documentation 5.24.2022-5.26.2022 D) Compliance will be monitored by Medical reconsulting CNA charting 3 x 4 weeks then monthly x 2 in Findings will be presented	resides e vho are for anyone aled ffered a sented to a on e ords by week for months. monthly	6/20/20	
	(iii) For treatmer operations, as p with 45 CFR 164 (iv) For public he neglect, or dome activities, judicial law enforcement	it, payment, or health care ermitted by and in compliance	3,		to Quality Assurance Performance Improvement committee for purpose of analyzing and identifying trends, and to refor compliance and make recommendations.	ormance or the		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CA240000634

	(X3) DATE SURVEY COMPLETED	
555339 B. WING C	_	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE)3/2022	
MANORCARE HEALTH SERVICES-PALM DESERT 74-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION! PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME	(X5) COMPLETION DATE	
F 842 Continued From page 19 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) For a minor, 3 years after a resident reaches legal age under State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under \$483.50. This REQUIREMENT is not met as evidenced by; Based on interview, and record review, the facility failed, for two of five residents reviewed (Resident 3 and 4), to maintain accurate medical records in accordance with accepted professional standards and practice when staff failed to accurately document showers and bed baths. This failure could increase the potential for confusion to occur in the provision of necessary		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		555339	B. WING			C	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	06/0	03/2022
MANOR	CARE HEALTH SERVI	CES-PALM DESERT		7	74-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROFICIENCY)			(X5) COMPLETION DATE
F 842	Continued From pa	ge 20	F8	342			
	Findings:						
		at 10:40 a.m., an unannounced at the facility for the linked complaints.					
	reviewed. Resident on February 16, 202 2022, with diagnose fibrillation (afib-irreg	Resident 3's record was 3 was admitted to the facility 22, and readmitted on April 4, es which included atrial gular heart rhythm), and spinal of the spinal canal which can the spinal cord).					
	observed lying in be	at 11:25 a.m., Resident 3 was ed. During a concurrent 3 stated she received a (May 9, 2022).					
	Shower/Bath: Mond Days" indicated R	3's facility document, "Task: lay EveningsLook Back 30 esident 3 had a bed bath on shower on May 9, 2022.					
	Shower/Bath: Thurs	3's facility document, "Task: day EveningsLook Back 30 esident 3 refused on May 5, wer or bath.					
	Shower/Bath: PRN.	3's facility document, "Task!Look Back 30 Days" 3 refused on April 25, 2022, to ath.					ı
		ntation, Resident 3 received be bed bath, from April 11, 22.					

PRINTED: 06/08/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		555339	B. WING			06/0	03/2022
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-PALM DESERT			7	TREET ADDRESS, CITY, STATE, ZIP CODE 4-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	reviewed. Resident on April 10, 2022, watrial fibrillation, and device that delivers to regulate the rhyt. On May 10, 2022, sitting in a wheelch concurrent intervies shower two times a was yesterday (Markeview of Residen Shower/Bath: Wed 30 Days" indicate April 20, 2022. "No 27 and May 4, 202 Review of Residen Shower/Bath: Satu Days" indicated April 16, and 23, 20 marked May 7, 202 Per facility document three showers, from 2022. On May 10, 2022, conducted with the The DON stated rebed bath two times Certified Nursing Athe tasks; shower, refused. The DON refused a shower to the conducted as the conducted a shower to the condu	Resident 4's record was 4 was admitted to the facility with diagnoses which included d pacemaker (a medical selectric impulses to the heart hm). Resident 4 was observed air beside her bed. During a w Resident 4 stated she got a a week, and her last shower y 9). 4 4's facility document, "Task: nesday EveningsLook Back ded Resident 4 had a shower on t Applicable" was marked April 2. 4 4's facility document, "Task: rday EveningsLook Back 30 Resident 4 had a shower on 022. "Not Applicable" was	F	842			

Facility ID: CA240000634

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
					C			
		555339	B. WING			1	03/2022	
	PROVIDER OR SUPPLIER CARE HEALTH SERVI	CES-PALM DESERT		7	STREET ADDRESS, CITY, STATE, ZIP CODE '4-350 COUNTRY CLUB DRIVE PALM DESERT, CA 92260			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BF	(X5) COMPLETION DATE	
F 842	On May 10, 2022, a with CNA 1. CNA 1 shower or bed bath schedule, or as need On May 10, 2022, a interview and concucted with the Resident 3 had one documented for the stated Resident 4's Resident 4 received days. The DON stat	in interview was conducted stated residents received a two times a week per	F	342				