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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555247 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/11/2025 |
| NAME OF PROVIDER OR SUPPLIER Rancho Mirage Health and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 39950 Vista Del Sol Rancho Mirage, CA 92270 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents were treated with dignity and respect when staff awakened one resident in the middle of the night to ask if she wanted to be moved to another room, for one of three sampled residents (Resident A). This failure had the potential to cause unnecessary disruption, discomfort, and interfere with the resident's ability to attain her highest practicable physical, mental, and psychosocial well-being. On July 8, 2025 @ 11:09 a.m., an unannounced visit to the facility was conducted to investigate an allegation of resident rights issue. A review of Resident A's admission Record, indicated Resident A was admitted on [DATE], with diagnoses which included osteoarthritis (a chronic joint disease characterized by the breakdown of cartilage, the protective tissue that cushions the ends of bones in joints), and aftercare following joint replacement surgery. A review of facility document titled Notification of Room/Roommate Change Form, dated June 18, 2025, indicated, .Reason for Room Change .Resident Request-Prefers other room .Patient (Resident A) requested a room move on 6/18/25. She was offered a room on station 2 but declined at that time. She was then again offered that evening and stated she will move in the morning .On July 8, 2025, at 4:39 p.m., during an interview with the Certified Nurse Assistant (CNA), the CNA stated he worked night shift from 10:30 p.m. to 6:30 a.m. The CNA stated on June 18, 2025, earlier in the shift, the outgoing Registered Nurse (RN) instructed him to ask Resident A if she wanted to have room change to occur that night or the following day. The CNA stated he went to Resident A's room, around 11 p.m. to 11:15 p.m., and asked if she wanted to move that night or tomorrow. On July 8, 2025, at 4:55 p.m., during an interview with the Director of Nursing (DON), the DON stated the facility's practice is to discuss room changes with residents when they are awake and not to disturb them during sleep to ask such questions. A review of the facility's undated document titled Resident 's [NAME] of Rights , indicated . Resident has to be treated with consideration, respect and full recognition of dignity and individuality. A review of the facility's undated policy and procedure titled Transfer, Room To Room, indicated, .Unless Medically necessary or for the safety and wellbeing of the resident(s), a resident will be provided with an advance notice of the room transfer.</p> |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 555247 |
| | | If continuation sheet Page 1 of 1 |