STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555443	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HI-Desert Medical Center D/P Snf	6601 White Feather Road Joshua Tree, CA 92252

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47110 Based on interviews, and record review, the facility failed to ensure the controlled medication (medications that can cause physical and mental dependence) was kept securely within the facility for one resident (Resident 1) when License Vocational Nurse (LVN 1) took Resident 1 ' s acetaminophen and hydrocodone (Norco-one of controlled medications that combine two types of medications together for pain control) from the medication cart without permission. This failure had resulted in diversion (medication illegally going to someone without a prescription) of controlled medication, which had the potential formisuse of drugs and stealing of Resident 1 ' s medication that could put Resident 1 at risk for inadequate relief of pain. Findings: During a review of Resident 1 Face Sheet (contain resident demographic), the Face Sheet indicated, Resident 1 was admitted on [DATE], with a diagnosis of unspecified focal traumatic brain injury (brain injury that is caused by an outside force). A review of Resident 1 ' s Orders, dated August 8, 2024, indicated, Norco 5-325 milligram (mg-unit dosing medication, a combination of 325 mg of acetaminophen and 5 mg of hydrocodone) was ordered to be given as needed for moderate pain (pain scale to evaluate pain level of patients). A review of Resident 1 ' s Orders, dated August 8, 2024, indicated, Norco 10-325 mg was ordered to be given as needed for severe pain. During an interview on August 22, 2024, at 10:40 AM, with the Administration (Admin) and the Director of Nursing (DON), the Admin stated, on August 19, 2024, Registered Nurse (RN 1) reported there was a discrepancy with Resident 1 ' s Norco during the controlled medication verification with LVN 1. The Admin further stated he was unable to find Resident 1 ' s pill cards (packages doses of medication within small, clear, or light-resistant, amber-colored plastic bubbles) of Norco 5-325 mg and Norco 10-325 mg. The Admin added there were 13 tablets of Norco 5-325 mg as well as 5 tablets of Norco 10-325 mg that were missing (total of 18 tablets missing) from the medication cart. (continued on next page)

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

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

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on August 26, 2024, at 10:40 AM, with RN 1, RN 1 stated, there was a discrepancy with Resident 1 ' s Norco 10-325 mg when RN 1 verified with LVN 1. RN 1 further stated, LVN 1 then took the pill card and all the remaining medication home while she went to report the discrepancy to the facility ' s management. RN 1 denied seeing Resident 1 ' s pill card of Norco 5-325 mg or any remaining medication during the controlled medication verification with LVN 1. During a telephone interview on August 27, 2024, at 9:35 AM, with LVN 1, LVN 1 stated, he could not explain the discrepancy or missing of Norco 10-325 mg during the medication verification. LVN 1 admitted taken the pill card of Norco 10-325 mg along with the remaining tablets back to his home and destroyed them. LVN 1 stated, I didn ' t want to have it. LVN 1 further stated, he did not know anything about Norco 5-325 mg. A review of the facility ' s policies and procedures (P&P) titled, Nursing Care Center Pharmacy Policy & Procedure Manual subtitled, Medication Storage Controlled Medication Storage, dated 2007, indicated, .10. Controlled medications are not surrendered to anyone, including the resident's prescriber other than releasing controlled medications for a resident on pass or therapeutic leave, to a resident or responsible party upon discharge from the nursing care center, or to the DEA [Drug Enforcement Administration] or other law enforcement officials functioning in a professional capacity in exchange for a receipt documenting the transaction. (Refer to Section 6.1 - Out-on-Pass (Leave of Absence) Medications and Section 5.2-Discharge Medications) .

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47110 Based on interviews, and record review, the facility failed to maintain an accurate controlled medication (medications that can cause physical and mental dependence) verification process for a universe of 17 residents when the controlled medication verification was not accurately completed with two (2) licensed nurses for seven (7) of 20 days from August 1, 2024, through August 20, 2024. This failure had the potential in delaying the recognition of any discrepancy to the controlled medication which can negatively affect residents ' health from misuse of medication or diversion (medication illegally going to someone without a prescription) of medication to unauthorized people. Findings: During a review of the facility ' s control drug count record for 17 residents, dated August 1, 2024, through August 20, 2024, the record indicated, missing one license nurse signature on the following days and shift (work hours): On August 1, 2024: AM shift (work shift that starts at 7:00 AM and ends at 7:00 PM) On August 4, 2024: AM shift. On August 6, 2024: PM shift (work shift that starts at 7:00 PM and ends at 7:00 AM) On August 7, 2024: AM shift. On August 10, 2024: PM shift. On August 11, 2024: AM shift and PM shift. On August 20, 2024: PM shift. During an interview on August 26, 2024, at 11:30 AM, with the Director of Staff Development (DSD), the DSD stated that nursing staff were trained to verify the controlled drugs daily with two nurses at the beginning and end of shift. During a telephone interview on August 26, 2024, at 12:55 PM, with the Pharmacist Consultant (PC), the PC stated that some of the drug count sheets processed for August 2024 showed only one nurse signature which should have been two nurses ' signature. During a telephone interview on August 28, 2024, at 9:16 AM, with the Administrator (Admin), the Admin stated he recently became aware that the controlled drugs was counted by one nurse as opposed to two nurses on some days in August 2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of facility ' s P&P titled Medication Administration, dated March 15, 2017, indicated, High Alert Medications: 1. High alert medications, as indicated in Table 1 and 2 of the High Alert Medication Independent Double Check Policy will be checked by two licensed nurses prior to administration. A list of these medications is posted at each automated dispensing cabinet. 2. Both nurses will document the verification process in the MAR to indicate that this has been completed .