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	08/06/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy and procedure (P&P) for resident abuse for one of three sampled residents (Resident 1) when Resident 1's care plan (an individualize treatment plan) was not updated or revised and enhanced monitoring was not implemented. This failure had the potential to result in Resident 1 having psychosocial (affecting person's feelings, emotions, relationships, and sense of well-being) harm to residents such as fear, anxiety and loss of trust in staff.Findings: An unannounced visit was conducted to the facility on August 5, 2025, for an investigation of a facility reported incident of abuse. During a review of Resident 1's Face Sheet (FS- a document containing patient demographics), the FS indicated, Resident 1 was admitted to the facility on [DATE]. A review of Resident 1's History and Physical (H&P - a document containing demographic information), dated January 8, 2025, indicated Resident 1 has a history of depression (feeling sad, hopeless for long period), paraplegia (unable to move or feel both legs) secondary to self-inflicted gunshot wound, and left sided weakness. During an interview on August 5, 2025, at 3:14 PM, with Resident 1, Resident 1 claimed Certified Nurse Assistant (CNA 1) hit him on his buttocks and thighs while getting dressed. Resident 1 stated he did not want CNA 1 to get fired, he was just concerned that if he did not say anything it would happen again. During an interview on August 5, 2025, at 4:11 PM, with the Director of Nursing (DON), the DON stated that CNA 1 was suspended until the investigation completed. The DON further stated no inventions were in place in the care plan to monitor Resident 1 during the investigation process. The DON stated she was unable to substantiate the allegation at this time. During an interview on August 6, 2025, at 11:37 AM, with the DON, the DON stated that the importance of the care plan is to make everyone aware of incidents and it is important to be used on the residents to make sure they are emotionally and psychosocially ok after an abuse allegation. During a concurrent interview and record review on August 6, 2025, at 12:42 PM, with the DON, the P&P titled Resident abuse, neglect, prevention, investigation, and reporting, dated August 18, 2021, was reviewed. The P&P indicated, .During the investigation process, actions will be taken to assure the residents health and safety. This includes but is not limited to: Assessment, care planning, supervision of resident, assignment of staff and monitoring the support, needs and behaviors of the residents.staff member responsibility. Director of nursing.will oversee the process for reporting, investigating, interventions and corrective action taken during the incident. The DON stated that the policy was not followed, and she should have updated the care plan right away.

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

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	08/06/2025

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

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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	08/06/2025

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

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy and procedure (P&P) for resident documentation of care plan for one of three sampled residents (Resident 2) when Resident 2's care plan (an individualize treatment plan) was not updated with description of changes in Resident 2's condition and behaviors. This failure had the potential to result in Resident 2 deterioration, emotional distress and an increase in the risk of injury to self, other residents, and staff.Findings: An unannounced visit was conducted to the facility on August 6, 2025, for an investigation of a facility reported incident of resident abuse. A review of Resident 1's Face Sheet (FS- a document containing patient demographics), the FS indicated, Resident 1 was admitted to the facility on [DATE]. A review of Resident 1's History and Physical (H&P - a document containing demographic information), dated March 2, 2025, indicated, Resident 1 has a history of depression (feeling sad, hopeless for long period), cerebrovascular accident (CVA- known as a stroke where the blood flow to the brain is disrupted causing brain damage), complete immobility due to severe physical disability, diabetes (high blood sugar), and hypertension (high blood pressure) A review of Resident 2's FS indicated, Resident 2 was admitted to the facility on [DATE]. A review of Resident 2's H&P, dated September 6, 2024, indicated, Resident 2 has a history of subdural hemorrhage (a bleed between the brain and its outer covering (the dura) caused by a head injury), expressive and receptive (able to receive) aphasia (difficulty speaking, understanding, reading, or writing because of brain damage), dementia (condition where a person's memory, thinking, and ability to make decisions gets worse over time because of damage to the brain). A review of Resident 2's SS [Social Service] note, dated August 5, 2025, by the Social Worker (SW), indicated the inappropriate language and behavior from Resident 2 toward Resident 1, .I am extremely concerned about the safety of [Resident 1] . there is a pattern of inappropriate and potentially unsafe behavior. During an interview on August 6, 2025, at 1:25 PM, with Resident 1, Resident 1 stated she is friend with Resident 2, she is afraid of Resident 2 because he gets angry at other people. During an interview on August 6, 2025, at 2:55 PM, with the SW, the SW stated that when she attempted to speak with Resident 2 regarding reports of Resident 2 feeding Resident 1, Resident 2 becoming upset when staff instructed him to leave Resident 1 alone, and Resident 2 responded No and walked away. During an interview on August 6, 2025, 3:24 PM, with Registered Nurse (RN1), RN1 stated, Resident 2 has been overly aggressive within the last week. A review of Resident 2's nursing narrative (a note done by the nursing staff), dated July 22, 2025, indicated .patient [Resident 2] was observed screaming, yelling and slamming room door. During a concurrent telephone interview and record review on August 12, 2025, at 4:02 PM, with RN1, Resident 2's LTC [Long Term Care] Neurological IPOC [Individual Plan of Care] (long term care plan- document that has the plan of care for resident regarding things to do with brain), dated May 19, 2025, was reviewed. The long-term care plan indicated, .document in Ad Hoc Form [area where nursing staff can document] every outburst, elevation in voice or aggressive behavior last evaluated on June 24, 2025. RN1 verified that the last time a nursing staff documented on Ad Hoc Form was June 24, 2025. RN 1 stated that Resident 2's nurse should document any time Resident 2 had an outburst, elevation in voice or aggressive behavior. RN1 stated that the plan of correction should have been updated since Resident 2 has been having outburst within the last week. During a concurrent telephone interview and record review on August 12, 2025, at 4:28 PM, with the Director of Nursing (DON), the facility's P&P titled, Documentation guidelines, dated October 17, 2016, was reviewed. The P&P indicated . all of the active nursing problems identified in the care plan and problem lists are included in the EHR Information or observations related to the problems are addressed . State the resident's response to nursing actions . Care plan updates will be done by adding the new information to the plan and dating the addition . description of changes in residence condition and behaviors . The DON stated that the policy regarding documentation of care plan was not followed and should have been. The DON stated that it is important for the nursing staff to follow and document on the care plan because it is a form of communication and it alerts the staff that follows.