

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555443	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/25/2025
NAME OF PROVIDER OR SUPPLIER  HI-Desert Medical Center D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.  (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed in response to safety concerns with suspected abuse for one of three sampled Residents (Resident 1) when the facility reported the suspected abuse to the California Department of Public Health (CDPH) on August 20, 2025, or five (5) days after the suspected abuse incident. This failure had the potential to result in a delay of an investigation to determine abuse which could continue or become more severe, other vulnerable Residents to be put at risk for abuse, worsen long-term psychological and physical effects, delay timely access to medical, psychological, and other services for healing for Resident 1. Findings: During a review of the facility's SOC 341 (California form used by specific people, called mandated reporters, to report suspected abuse or neglect of elders and dependent adults), dated August 20, 2025, at 1:00 PM, the SOC 341 indicated that Licensed Vocation Nurse (LVN2) reported on Friday (August 15, 2025, at 1:00 PM), (Visitor) friend of Resident 3 entered room [ROOM NUMBER] and was observed touching (Resident 1) . without her consent. (LVN2) instructed (Visitor) 'not to touch (Resident1), or her meal tray'.(Visitor) was instructed to leave and he refused. CNA1 (Certified Nursing Assistant) reported witnessing him eating food from (Resident 1's) tray. Staff instructed (Visitor) to leave and he refused. Staff concerned for safety. (Visitors) presence in resident rooms interferes with care, disrupts residents and impedes (licensed nursing) ability to perform duties as a nurse. During a review of Resident 1's admission History and Physical (H&amp;P), dated March 25, 2025, the H&amp;P indicated Resident 1 had medical history of diabetes (a chronic condition that affects how the body uses sugar [glucose] which will make the blood sugar levels high), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to perform activities of daily living), chronic obstructive pulmonary disease (COPD - lung and airway diseases that restrict your breathing), and hypertension (HTN - the force of blood flowing through your blood vessels continues to be too high over time). During a review of Resident 1's nursing note, dated August 16, 2025, at 5:28 PM, the nursing note indicated, Resident 3 had a visitor who entered the room and woke up Resident 1.(LVN2) instructed (the visitor) not to touch V or (Resident1) meal tray. (The Visitor) responded by stating that (LVN2) did not know what (LVN2) was talking about and claimed (Resident1) was pretending to be asleep. (LVN2) explained that (Visitor) is not an employee and should not be entering resident rooms or disturbing other residents. I directed (the Visitor) to leave at that time. However, there was limited support, and (the Visitor) did not leave. Another CNA later reported witnessing (Visitor) eating food from (Resident1's) tray. I told (Visitor) he needed to leave that he was not to wake up or disturb other residents. (The Visitor) did not leave and there was a concern for (LVN2's) safety as we do not have security up here. When this visitor is seated in the dining room with (Resident3), there are no issues. However, his presence in resident rooms interferes with care, disrupts residents, and impedes my ability to perform my duties as a nurse. During a review of CNA1's statement, dated August 20, 2025, the CNA1's statement indicated, On 8/15 [August 15] I observed a pts visitor, [Resident 1] shares room with pt, visitor approached while [Resident 1] sitting on her bed, attempting to eat off of [Resident 1] plate, visitor touched [Resident 1] hand, this writer made (LVN2) aware, visitor was asked to leave room. During an interview on August 25, 2025, at 11:32 AM, with the Director of Nursing (DON), the DON stated, the visitor placed his hand on Resident 1's arm and he had been interfering with Resident 1's care. The DON stated from what the nurse told me [the visitor] was touching [Resident 1] by helping [Resident 1] get in and out of bed. feeding [Resident 1] and taking food off [Resident 1's] tray. [Resident 1] is a diabetic and [Resident 1] has Alzheimer's [a form of dementia] and unable to consent. [CNA1] gave a statement where she observed [the visitor] eating off [Resident 1's] plate and touching [Resident 1's] hand and [the visitor] was asked to leave the room. The DON stated LVN2 tried to get the visitor to leave Resident 1's room on August 15, 2025, and he refused. The DON stated LVN2 was concerned about Resident 1's safety. The DON stated she was made aware of LVN2's nursing note that informed of the event on August 20, 2025 (five days after the incident). The DON stated that everybody was a mandated reporter and should report right away which did not occur. During an interview on August 25, 2025, at 1:44 PM, with LVN2, LVN2 stated she observed the visitor enter Resident 1's room accompanied by Resident 3 where she had line of sight and I saw [the visitor] lean over [Resident 1]'s bed to try to wake her up. And I don't know 100% if [the visitor] touched [Resident 1]. I said please don't wake her up. Then [the visitor] touched [Resident 1]'s meal tray and said to me he was trying to wake her up and help her eat. I told [the visitor] to please leave the room and he was asking why. I said</p>		