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	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HI-Desert Medical Center D/P Snf	6601 White Feather Rd 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to protect two of three sampled residents (Resident 1 and 3) from verbal abuse (suing negative words and language that cause harm) from Registered Nurse (RN 1). This failure had the potential to contribute to Resident 1 and 3 distrust in the healthcare team which could negatively affect Resident 1 and 3 participating in their care that could lead to actual harm and worsen their condition.Findings: During a review of Resident 1's History and Physical (H&P), dated July 15, 2025, the H&P indicated that Resident 1 was admitted with a diagnosis of multiple sclerosis (a disease that causes breakdown of the protective covering of nerves which can cause numbness, weakness, pain, trouble walking, weakness, vision changes, fatigue, mood changes and other symptoms). During a review of Resident 1's Brief Interview Mental Status (BIMS - test used in nursing homes and hospitals to measure a person's memory and thinking skills where a score of 13 to 15 is considered normal), dated January 24, 2026, the BIMS indicated that his score was 15. During a review of Resident 3's H&P, dated May 14, 2025, the H&P indicated that Resident 3 was admitted after acute hospitalization for an accident-causing bone fractures with anticipated extended healing process. During a review of Resident 3's BIMS, dated November 21, 2025, the BIMS indicated that his score was 15. During an interview on March 3, 2026, at 2:48 PM, with Resident 2, Resident 2 stated RN 1 was yelling at Resident 1 and RN 1 said she did not have to deal with administering medication to Resident 1 right now and she was already late. Resident 2 stated RN 1 was aggressive and yelled. Resident 2 stated Resident 1 was upset and angry and Resident 2 went to Resident 1's room and calmed him down. During an interview on March 3, 2026, at 2:54 PM, Resident 1 stated when he asked RN 1 about the timeliness of his medications, she [RN 1] started freaking out and yelling. Resident 1 stated he withdrew from the area and I could hear her [RN 1] bad mouthing me or it was toward someone else .I couldn't hear exactly what she [RN 1] was saying in the hall. Resident 1 further stated I blocked it out and put on my headphones, and it made him feel like shit, like I wanted to kill somebody. Resident 1 stated it made him feel crazy and anxious because he needed his mediation for his chronic pain due to trigeminal neuralgia (a chronic pain disorder that involves sudden attacks of severe facial pain affecting the trigeminal nerve). During a concurrent observation and interview on March 3, 2026, at 3:10 PM, with Resident 3, Resident 3 stated he overhead Resident 1 got upset when his medications were not on time and when Resident 1 asked RN 1 about the timing of his medication for his pain, RN 1 then started yelling at Resident 1. Resident 3 stated RN 1 was very unprofessional and disrespectful. Resident 3 stated he could not hear what RN 1 was saying but emphasized that he could hear RN 1 yelling when he is four doors down from Resident 1's room. Resident 3 stated he expressed anxiety about having any potential interactions with RN 1 after she was yelling at Resident 1. Resident 3's room is approximately 40 feet from Resident 1's room. During an interview on March 3, 2026, at 3:25 PM, with Social Services (SS), SS stated she met with Resident 1, 2 and 3 after the incident of alleged verbal abuse. SS stated Resident 1, 2, and 3 reported that RN 1 tone may have been loud toward residents and RN 1 may not have been able to maintain her composer in the stressful situation. SS stated that from the report, RN 1 was inappropriate and failed to maintain her composure by being loud talking and dismissive to (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1. During an interview on March 3, 2026, at 3:55 PM, with the Director of Nursing (DON), the DON stated the staff who reported the incident were Certified Nursing Assistants, CNA 1 and CNA 2. The DON stated she felt that this was verbal abuse from the yelling that could be heard down the hallway. During an interview on March 4, 2026, at 9:19 AM, with CNA 1, CNA 1 stated that Resident 3 reported to her that he could hear RN 1 yelling at Resident 1 about medication he asked about. CNA 1 stated, Resident 3 was not happy to hear the yelling from RN1 towards Resident 1. During an interview on March 4, 2026, at 9:36 AM, with CNA 2, CNA 2 stated that Resident 3 reported RN 1 was irritated and was yelling at Resident 1. CNA 2 stated that before the incident, she had heard RN 1 talk a little loud toward others. During a review of the facility's policy and procedure (P&P) titled, Resident abuse, neglect prevention, investigation and reporting, dated October, 18, 2021, the P&P indicated, Definition: Verbal abuse: Verbal abuse is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again. Additionally, this includes making any statement which causes the resident to be degraded, embarrassed or otherwise attacks the resident's right to be treated with dignity including using foul language towards a resident or using a tone of voice towards the resident that causes him/her to be frightened and/or feel threatened. The tone of the voice, not the content of the message, may be considered to be abusive.Behavioral Indicators from the Victim: .Fear.Depression, Helplessness, Resignation.Withdrawal.Anger.Agitation, anxiety.