| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555443 | A. Building<br>B. Wing | 05/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HI-Desert Medical Center D/P Snf | 6601 White Feather Rd<br>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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate supervision and implement elopement (when a resident leaves facility without staff's permission) preventions for one of three sampled residents (Resident 1), who was assessed as having a high elopement risk. This failure resulted in Resident 1 leaving the facility unsupervised, fell, and subsequently sustained a left hip fracture (broken).Findings: A review of Resident 1's face sheet (contains demographic and medical information), undated, indicated, Resident 1 was admitted on [DATE], with diagnoses including sepsis (serious body-wide reaction to an infection that can damage organs) and dementia (condition that causes memory loss and trouble thinking, severe enough to affect daily life). A review of Resident 1's Elopement Risk Assessment [a tool to identify individuals likely to leave a facility unsupervised, reducing risk of injury], dated March 3, 2026, indicated, Resident 1 had dementia, wandering behaviors (when an individual moves around without clear purpose and may become lost, confused, or unsafe), and was identified as a high elopement risk. A review of Resident 1's Minimum Data Set [MDS - standardized, comprehensive assessment tool used to evaluate resident functional capabilities, health needs, and quality of life], dated March 12, 2026, indicated Resident 1 had diagnosed cognitive loss (gradual reduction in the brain's ability to function as well as it used to) or dementia (decline in brain function that interferes with daily life, caused by diseases that damage brain cells). During an interview on April 22, 2026, at 12:40 PM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated she was informed that Resident 1 eloped from the facility on April 16, 2026, around 9:30 AM. LVN 1 added the facility's staff did not see Resident 1 left. LVN 1 confirmed Resident 1 wandered frequently throughout the facility. During a follow-up concurrent observation and interview on April 22, 2026, at 12:50 PM, with LVN 1, the facility's exit doors were observed. The facility's entrance door was unlocked with no alarm, leading to the parking lot that led to a major street. No staff were present in main lobby while residents were observed walking back and forth. The facility's back door leading to the outdoor smoking patio and extended parking lot, was also unlocked with no alarm, and no staff present. LVN 1 confirmed the facility is not a locked unit and that the front entrance and side door leading to the parking lot are unlocked and unalarmed. During an interview on May 6, 2026, at 10:53 AM, with the Admin Secretary (AS), in the main lobby, the AS stated she last observed Resident 1 on April 16, 2026, between 8:30 AM and 9:00 AM. The AS further stated, Resident 1 was observed sitting in the lobby before the AS stepped away from the front desk, then upon return, Resident 1 was no longer in the main lobby. During an interview on May 6, 2026, at 11:02 AM, with Certified Nurse Assistant 1 (CNA1), CNA1 confirmed that he was assigned to Resident 1 on April 16, 2026, during day shift (7:00 AM to 7:00 PM). CNA1 stated he last observed Resident 1 in her room around 8:30 AM and did not see Resident 1 afterwards. CNA1 confirmed Resident 1 frequently wanders the facility and has dementia. CNA1 further stated it was facility expectation for the staff assigned to the residents to monitor and ensure residents' safety. During an interview on May 6, 2026, at 11:27 AM, with LVN 2, LVN 2 confirmed Resident 1 was one of her residents on April 16, 2026, for day shift. LVN 2 stated she last observed Resident 1 in the hall approximately around<br>(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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 8:00 AM. LVN 2 stated Resident 1 often wanders the facility but has never actually left the building. LVN 2 further stated it was facility expectation for staff to monitor residents every two hours with high elopement risk and dementia. LVN 2 was unsure what interventions were on Resident 1's care plan (individual plan that includes residents' health problems, preferences, and goals) for elopement risk and dementia. During a concurrent interview and record review on May 6, 2026, at 12:05 PM, with the Director of Nursing (DON), Resident 1's Nursing Notes, dated April 4, 2026, through April 16, 2026, were reviewed. The Nursing Notes indicated that Resident 1 would often walk throughout the facility, demonstrating confusion and difficulty with redirection, and escalating behavioral concerns. The DON verified Resident 1 was known to be a wander risk, had dementia, and staff relied primarily on frequent checking and redirection. The DON further stated no staff observed Resident 1 leave the building and there were no staff in the lobby or outside the front entrance, on the date of the incident, April 16, 2026. During a concurrent interview and record review on May 6, 2026, at 12:15 PM, with the DON, Resident 1's LTC [long term care] Elopement Risk IPOC [interdisciplinary plan of care] (IPOC), dated April 17, 2026, was reviewed. The IPOC indicated, Resident 1 had a plan of care for elopement risk, which had an intervention of structure day to monitor activities and safety. The DON confirmed there were no other interventions in the elopement IPOC, and the IPOC was not specific to Resident 1's concerns. The DON stated there was no clear guidance for staff to follow to prevent elopement risk. The DON was unable to provide a plan of care for dementia. During a concurrent interview and record review on May 6, 2026, at 2:15 PM, with the DON, the facility's policy and procedure (P&P) titled, Accident Prevention, dated January 2020, was reviewed. The P&P indicated, .Avoidable Accident: means that an accident occurred because the facility failed to:.A. Identify environmental hazards and individual resident risk of an accident, including the need for supervision; and/or.B. Evaluate/analyze the hazards and risks; and/or.C. Implement interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident; and/or.D. Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current standards of practice. The DON stated the policy was not followed and it should have been followed to ensure Resident 1's safety. During a phone interview on May 6, 2026, at 3:25 PM, with the Director of Rehabilitation (DOR), the DOR stated, on April 16, 2026, around 10:00 AM, she saw Resident 1 outside the facility, unsupervised by staff, walking down the hill on the street. The DOR also noted that Resident 1 appeared to be confused. The DOR stated that while waiting for backup, the DOR proceeded to follow Resident 1 down the hill. The DOR then observed Resident 1 fall backward. Subsequently, the DOR contacted emergency services and arranged for Resident 1 to be transferred to the affiliated General Acute Care Hospital. A review of Resident 1's admission H&P [History and Physical-an initial physical assessment], dated April 16, 2026, indicated Resident 1 was brought into the Emergency Department (ED) for a fall after Resident 1's eloped from the Continuing Care Center (CCC), resulting in left leg fracture. |