STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055539	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Artesia Christian Home Inc.	11614 E. 183rd St Artesia, CA 90701

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49889 Based on interview and record review the facility failed to ensure Resident was assessed and evaluated after an unwitnessed fall on 12/7/2024 for one out of 2 high risks for falls (Resident 1). This deficient practice resulted in Resident 1 falling in bed sustaining multiple skin tears to the left forearm. Findings: During a review of Resident 1's Face Sheet dated 12/30/24, the face sheet indicated Resident 1 was admitted to facility with diagnoses including mild cognitive impairment (changes in thinking and memory), Atrial Fibrillation (irregular heart rate), foley catheter use(thin flexible tube that drains urine from the bladder into a collection bag), glaucoma (chronic eye disease), muscle wasting and atrophy (loss of muscle mass) and difficulty walking, history of falls. During a review of Resident 1's History and Physical (H&P) dated 11/8/24 indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ({MDS}- a resident assessment tool) dated 11/18/24 the MDS indicated Resident 1 has severe cognitive impairment. The MDS also indicated Resident 1 was dependent (helper does all the work) with activities of daily living ({ADL's}- activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 1's Physicians Order Report dated 11/30/24-12/30/24 indicated, Resident1 has orders for Dulcolax suppository 10mg give once a day as needed. The physician orders report also indicated Resident1 has orders for pressure pad alarm at all times in bed to monitor getting out of bed without assistance. During a review of the Medication Administration History dated 11/30/24-12/30/24 indicated Resident 1 was given a Dulcolax suppository on 12/24/24 at 6:23 a.m. During a review of Resident 1's Progress Note dated 12/24/24 the progress note indicated Resident 1 was transferred to a general acute care hospital (GACH) on 12/24/24 at 12:22 p.m. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/30/24 at 6:26 am with Certified Nursing Assistant (CNA) 1, CNA 1 stated that Resident 1 is impulsive and sometimes he doesn't use the call light. CNA 1 stated Resident 1 had been given a suppository at 5:30 a.m. and the last time she saw the resident was at 6:00 a.m. and at 7:00 a.m. CNA 1 stated that it is important to check on residents after they have been given a suppository, for safety reasons the resident could fall trying to get up to go to the bathroom. During an interview on 12/31/24 at 7:30 am with CNA 2, CNA 2 stated he was given report at 6:30 a.m. on 12/24/24 that Resident 1 was given a suppository. CNA 2 stated the last time he saw Resident 1 was around 6:45 a.m. and that Resident 1 was asleep. CNA 2 stated that at around 7:00 a.m. he heard the alarm and he found Resident 1 on the floor and his diaper was full of bowel movement (BM). During an interview on 12/30/24 at 7:25 a.m. with Licensed Vocational Nurse (LVN), LVN1 stated that Resident 1 was confused and did not really use his call light LVN 1 stated Resident 1 was given a suppository around 5:30 a.m LVN 1 stated that she did not check to see if Resident 1 had a BM she asked CNA 1 at 6:00 a.m. LVN 1 stated that around 7:00 am she was called to Resident 1's room, and he was on the floor with BM in his diaper. LVN 1 stated that when a resident is given a suppository the CNA needs to check on the residents every 30 min until resident has a bowel movement because resident could try to get up get up and fall During an interview on 12/30/24 at 11:17 a.m. with Assistant Director of nurses (ADON), The ADON stated Resident 1 has poor safety awareness and is very impulsive ADON added that Resident 1 had fallen from the wheelchair 3 times, 2 times trying to go to the bathroom and one time in the hallway. ADON stated that when a resident falls the nurses need to do a change of condition (COC), a fall risk evaluation, care plan and Director of Nurses (DON) does the post fall assessment. ADON stated that when residents are given a suppository the CNA's and the charge nurses need to check the resident every 30min to one hour after suppository is given if resident are not checked they can get skin break down or residents could fall trying to go to bathroom. During a concurrent interview and record review on 12/30/24 at 11:17 a.m. with, the ADON indicated Resident 1 did not have a fall risk evaluation done after his unwitnessed fall on 12/7/24 and that the fall risk evaluations are important because they asses for changes in the resident that might be contributing to the fall. During an interview on 12/31/24 at 9:00 a.m. with, the Director of Nurses (DON), the DON stated she was aware that Resident 1 had fallen multiple times in the last month and that no fall risk evaluation was done after the fall on 12/7/24, and that she must have missed it. The DON stated that fall risk evaluations are important because you can see if there are any functional changes you could miss some type of visual cue, DON also said it can show you that you may need to change your plan of care. DON stated that after every fall a Fall risk evaluation must be done. DON stated that she expects her nursing staff to check on a resident every 30 min after a suppository is given. DON stated there is a safety concern when given a suppository because it stimulates you makes you want to go to the bathroom. DON stated there is a potentially for the resident to fall and have an injury needing to go to the bathroom. During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing dated 12/2007, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling and to try and minimize complications.