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	07/09/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview and record review, the facility staff failed to ensure one of three sampled residents (Resident 1) left arm bruise was assessed and reported as a change of condition after being reported to a licensed nurse. This deficient practice resulted in a delay of care for Resident 1 and had the potential to cause pain, infection and lead to hospitalization. Findings: During a review of Resident 1’s admission Record, the admission Record indicated Resident was 1 admitted to the facility to the facility on 6/2/2025 with a diagnosis including unspecified dementia (decline in mental ability severe enough to interfere in daily life) , unspecified severity, without behavioral disturbance, hypertension (high blood pressure) and anxiety (having constant worry and fear). During a review of Resident 1’s MDS a resident assessment tool) dated 6/12/2025, the MDS indicated Resident 1’s cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) were severely impaired. The MDS indicated Resident 1 was dependent (resident does none of the effort to complete the activity. Or, the assistance of two or more helpers is required for the resident to complete the activity) on eating, oral hygiene, sit to lying, chair/bed to chair transfer, toilet hygiene, tub/ shower transfer, oral hygiene and upper body dressing (arms/shoulders). During a review of Resident 1’s admission Body/ Skin Assessment (BSA) dated 6/2/2024, the BSA indicated Resident 1 had a purple/red discoloration measuring 8. 5 X 10 cm (centimeters- unit of measure) to left arm. During review of Resident 1’s untitled Care Plan (CP) dated 6/2/2025. The CP indicated Resident 1was admitted with purplish skin discoloration on left arm about 8.5x 10 cm. monitor and report any signs of localized infection (swelling, redness, pain or tenderness, heat at the affected area, purulent drainage, or bruises and report any significant changes. During a review of Resident 1’s Event Report (ER) dated 6/28/2025 at 7:13 p.m., the ER indicated a skin discoloration to left arm and elbow measuring 25 cm x 17 cm (increased in size from admission). During a review of Resident 1’s ER dated 6/28/2025 at 9:46 p.m., the ER indicated Certified Nurse Assistant 2 (CNA 2) reported to Licensed Vocational Nurse 2 (LVN 2) Resident 1 had discoloration to the left arm. (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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Artesia Christian Home Inc.	11614 E. 183rd St Artesia, CA 90701

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1’ s Radiology report dated 6/29/2025 the report indicated there was an acute fracture (a sudden break in the bone) involving the neck of the left humerus (the long bone located in the upper arm extending from the shoulder to the elbow), with mild displacement. During an interview on 7/ 9/2025 at 1:45 p.m., with CNA 1, CNA 1stated she took care of Resident 1 on 6/28/2025 for 7 a.m. to 3 p.m. shift and saw Resident 1 trying to protect her left arm. CNA1 stated upon observing the left arm there was a large purplish bruise present. CNA 1 stated she reported her findings to her LVN 1. CNA 1 stated LVN 1 told her she would let the treatment nurse know about the bruise. During an interview on 7/9/2025 at 4:00 p.m., with LVN 1, LVN 1 stated he worked 6/28/2025 from 7 a.m. to 3:00 p.m. shift when CNA 1 reported Resident 1’ s bruise on the left arm to him. LVN 1 stated he looked in the chart and saw charting that Resident 1 had a bruise on the left arm on admission but did not go to assess the resident. LVN 1stated he told CNA 1 to report it to the treatment nurse. LVN1 stated it was important to assess Resident 1’s arm because there could be changes and the arm can get worse. During a telephone interview on 7/10/2025 at 2:30 p.m. with the Registered Nurse (RN) 1, RN 1 stated on 6/28/2025 she worked as a treatment nurse from 7 a.m. to 3 p.m. shift when LVN 1 told her Resident 1 has a purplish bruise to the left arm. RN stated she checked the charting in the computer and stated the bruise was already charted . RN stated she never went to assess Resident 1’s arm because she didn’t consider it a change in condition. RN 1 stated when someone reports a bruise it is her job to go and assess the bruise, she stated she should have looked at Resident 1’s arm when it was reported to her. RN 1 stated part of her assessment is to measure the size of the bruise, the color, if there is pain , appearance of the resident’s skin and chart her findings. RN 1 stated it is important to do an assessment to identify if there were any changes to the skin. RN 1 stated because the left arm went unnoticed the injury could have gotten worse. RN 1 stated this was a change of condition. During an interview on 7/11/2025 at 11 :15 a.m. with the Director of Nursing (DON), the DON stated the LVN can look at the resident’s arm chart and notify the doctor and the RN does a more thorough assessment document and notify the doctor. The DON stated the nurses chose to look at the documentation in the chart instead of looking at the resident’s arm. The DON stated it is important to do an assessment to confirm what is going on or if there are any changes, then the nurse must start a change of condition form (COC). The DON stated she knew the day shift did not assess the resident and this was a learning experience for the staff. A review of the facility's policies and procedures (P&P) titled, “Change in a Residents Condition or Status, revised December 2016, indicated, our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident’s medical/ mental condition and/or status (e.g., changes in the level of care, billing/payments, resident’s rights, etc.). The nurse will notify the resident’s Attending Physician or Physician on call when there has been a(an): accident or incident involving the resident. A significant change is a major decline or involvement in the residents’ status that will not normally resolve itself without intervention by staff or implementing standard disease-related clinical interventions (is not “self- limiting”). The P&P indicated the nurse will record in the resident’s medical record information relative to changes in the resident’s medical/ mental condition or status. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled, “Charge Nurse (RN/LVN), “job description undated, indicated the purpose of this position is to supervise, provide and coordinate nursing care in compliance with the facility policies and procedures, assess residents’ care needs, and take appropriate action.