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	11/15/2024

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on observation, interview and record review, the facility failed to ensure residents were assessed for the use of pressure pad alarms (pressure sensitive devices that sound if a resident's position changes) and either the residents or their representatives were given the choice to give informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for two of two sampled residents (Resident 27 and 2). This deficient practice resulted in a violation of resident rights to be free from restraints (any manual method, physical or mechanical device, equipment, or material that is adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement). Findings: During a review of Resident 27's Admission Record, the Admission Record indicated Resident 27 was originally admitted to the facility on [DATE] with diagnosis including dementia (a progressive state of decline in mental abilities). During a review of Resident 27's Minimum Data Set (MDS - a resident assessment tool), dated 10/10/2024, the MDS indicated Resident 27's cognition was severely impaired. The MDS indicated Resident 27 needed set up assistance when eating, partial assistance (helper does less than half the effort) when dressing, substantial assistance (helper does more than half the effort) with oral and personal hygiene and was dependent (helper does all the effort) on staff with toileting hygiene and showering. During a review of Resident 27's Physician Order Report dated10/11/2024 to 11/11/2024, the report indicated, starting 3/28/2024, Pressure pad alarm always when in bed/ wheelchair to monitor getting out of bed/ wheelchair without assistance. During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was originally admitted to the facility on [DATE] with diagnoses including muscle weakness, and end stage renal disease (ESRD -irreversible kidney failure). (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognition was intact. The MDS indicated Resident 6 needed partial assistance when eating, with oral and personal hygiene, and was dependent on staff with showering and toileting hygiene. During a review of Resident 6's Physician Order Report dated 10/11/2024 to 11/11/2024, the report indicated, starting 8/9/2024, Pressure pad alarm always when in bed/ wheelchair to monitor getting out of bed/ wheelchair without assistance. During an observation on 11/8/2024 at 7:21 p.m. Resident 6' and 27s bed was observed with pressure pad alarms. During an interview and record review on 11/11/2024 at 10:45 a.m., with the MDS Coordinator Resident 27 and 6's MDS were reviewed, and the MDS indicated Restraints and Alarms were in the same category. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated10/2019 was reviewed and the manual indicated the use of an alarm may meet the definition of a restraint, as the alarm may restrict the resident's freedom of movement and may not be easily removed by the resident. The manual indicated when an alarm was used as an intervention in the resident's safety strategy, the effect the alarm has on the resident must be evaluated individually for that resident. The MDS Coordinator stated the facility did not consider alarms as restraints, so the residents only have a physician's order. The MDS stated the residents or their representatives were not told of the risks and benefits of using the alarms so they can give informed consent. During an interview on 11/13/2024 at 3:01 p.m., with the Director of Nursing (DON), the DON stated restraints need a consent, an assessment, and a physician order. The DON stated they did not realize alarms were considered a restraint and all the residents have alarms when admitted . During a review of the facility's policy and procedure (P&P) titled, Use of Restraints revised 12/2007, the P&P indicated Physical Restraints were defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same way the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint. The P&P indicated residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use. The P&P indicated restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The P&P indicated prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to report an injury of unknown origin for one of one sampled resident (Resident 210), when Resident 210 was found to have a 1.5 centimeter (cm-unit of measurement) by 1.5 cm small bluish bump on the left side of her forehead, which staff and resident could not provide an explanation of its origin. This deficient resulted in a delay of an onsite inspection by the California Department of Public Health (CDPH) and had potential for an ongoing unknown injury. Findings: During a review of Resident 210's Admission Record, the Admission Record indicated Resident 210 was admitted on [DATE] with the diagnoses including pneumonia (an infection/inflammation in the lungs) and difficulty in walking. During a review of Resident 210's Minimum Data Set (MDS - a resident assessment tool) dated 9/3/2024, the MDS indicated Resident 210's cognition (the mental process involved in knowing, learning, and understanding things) was moderately impaired and Resident 210 required set up or clean up assistance (helper sets up and resident completes the activity) from facility staff when transferring from chair/bed to chair transfer. During a review of Resident 210's Progress Notes dated 7/27/2024, the Progress Notes indicated Resident 210's RP noticed a small bump on Resident 210's forehead and reported it to the charge nurse. The Progress Note indicated the charge nurse assessed Resident 210 to have a small bump and bluish discoloration on the left side of Resident 210's forehead. The Progress Noted indicated the outgoing shift staff did not report any fall or any injuries when they gave report about Resident 210. The Progress Note indicated Resident 210 uses a stand-up lift during transfer to and from the bed and it may have possibly caused the injury. During a review of facility's Post Incident (Non-Fall) Investigation Report dated 7/27/2024, the Post Incident (Non-Fall) Investigation Report indicated Resident 210's left side of her forehead had a bluish discoloration/bump that measured 1.5 cm by 1.5 cm. The Post Incident (Non-Fall) Investigation Report indicated the facility concluded Resident 210 required the use of the stand-up lift, which Resident 210 does not like and that causes her to become agitated, scream and yell. The Post Incident (Non-Fall) Investigation Report indicated Resident 210 possibly bumped the left side of her head on the sling hook on the stand-up lift or another part of the lift. During an interview on 11/13/2024 at 1:16 p.m., with the Director of Nursing (DON), the DON stated incidents that are reportable to the California Department of Public Health (CDPH) include falls with fractures or death, or injuries due to possible abuse. The DON stated she needed to investigate the bump on Resident 50 because it was unusual to have bruises on the face. The DON stated she assumed the bluish discolored bump was caused by Resident 210's dislike of the stand-up lift because she was uncooperative and agitated in the lift which might have caused the bruise. The DON stated she did not interview staff who worked with Resident 210 on 7/27/2024 (the date of the injury). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled Abuse policies & procedures dated 10/5/2022, the P/P indicated facility staff will report all violations involving mistreatment, neglect, abuse or injuries of unknown nature and misappropriation of resident property to the supervisor, the supervisor will report the incident to the Executive Director (ED), and the ED and the DON will investigate further, taking any necessary immediate action and shall report the incident according to facility policy and state law to the appropriate state agencies within the proper time frame.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to investigate injuries of unknown origin for one of one sampled resident (Resident 210). Resident 210 had a 1.5 centimeter (cm-unit of measurement) by 1.5 cm small bluish bump on the left side of her forehead, which staff and resident could not provide an explanation of its origin. This deficient practice had the potential for undetected abuse. Findings: During a review of Resident 210's Admission Record, the Admission Record indicated Resident 210 was admitted on [DATE] with the diagnoses including pneumonia (an infection/inflammation in the lungs) and difficulty in walking. During a review of Resident 210's Minimum Data Set (MDS - a resident assessment tool) dated 9/3/2024, the MDS indicated Resident 210's cognition (the mental process involved in knowing, learning, and understanding things) was moderately impaired and Resident 210 required set up or clean up assistance (helper sets up and resident completes the activity) from facility staff when transferring from chair/bed to chair transfer. During a review of Resident 210's Progress Notes dated 7/27/2024, the Progress Note indicated Resident 210's RP noticed a small bump on Resident 210's forehead and reported to the charge nurse. The Progress Note indicated the charge nurse assessed Resident 210 to have a small bump and bluish discoloration on the left side of Resident 210's forehead. The Progress Noted indicated the outgoing staff did not report any fall or any injuries for Resident 210. The Progress Note indicated Resident 210 used a stand-up lift (mobility equipment used to help a person transfer from a seated position to a standing position) during transfer to and from the bed and may have possibly caused the injury. During a review of facility's Post Incident (Non-Fall) Investigation Report dated 7/27/2024, the Post Incident (Non-Fall) Investigation Report indicated Resident 210's left side of her forehead had a bluish discoloration/bump that measured 1.5 cm by 1.5 cm. The Post Incident (Non-Fall) Investigation Report indicated the facility concluded Resident 210 required the use of the stand lift, which Resident 210 does not like and causes her to become agitated, screams and yells. The Post Incident (Non-Fall) Investigation Report indicated Resident 210 possibly bumped the left side of her head on the sling hook on the stand-up lift or another part of the lift. During an interview on 11/13/2024 at 1:16 p.m., with the Director of Nursing (DON), the DON stated incidents that are reportable to the California Department of Public Health (CDPH) include falls with fractures or death, or injuries due to possible abuse. The DON stated she needed to investigate the bump on Resident 50 because it was unusual to have bruises on the face. The DON stated she assumed the bluish discolored bump was caused by Resident 210's dislike of the stand-up lift because she was uncooperative and agitated in the lift which might have caused the bruise. The DON stated she did not interview staff who worked with Resident 210 on 7/27/2024 (the date of the injury). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P/P) titled Accidents and Incidents-Investigating and Reporting) dated 7/2017, the P/P indicated all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on the facility's premises shall be investigated and reported to the Administrator.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan addressing the resident's noncompliance for one of two sampled residents (Resident 1). This deficient practice had the potential to result in the delay of care and services. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] with diagnoses including Chronic respiratory failure (inadequate gas exchange in the body), generalized muscle weakness, and a gastrotomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 10/13/2024, the MDS indicated Resident 1's cognition was intact. The MDS indicated Resident 1 needed set up assistance with oral hygiene, moderate assistance (helper does less than half the effort) with personal hygiene, and was dependent on staff with showering, dressing and toileting hygiene. During an interview and record review on 11/11/2024 at 3:07 p.m., with the Assistant Director of Nursing (ADON), Resident 1's Behavior Quarterly Management Follow Up, dated 10/15/2024, was reviewed and the Behavior Quarterly Management Follow Up indicated Resident 1 did not comply with plan his plan of care regarding safety and feedings, and turning schedule. The Behavior Quarterly Management Follow Up indicated Resident 1 only wanted things his way even when it was not safe. The ADON stated Resident 1 was very particular and specific with his wants and needs and was oftentimes noncompliant with care and orders. During an interview and record review on 11/11/2024 at 3:07 p.m., Resident 1's care plans were reviewed, and the ADON stated Resident 1 did not have a care plan addressing Resident 1's noncompliance. The ADON stated we need a care plan because it ensures care rendered to residents are based on their needs and behaviors. During an interview on 11/13/2024 at 1:12 p.m., with the Director of Nursing (DON), the DON stated care plans need to be developed and implemented to guide resident care and treatment. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44055

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 CROSS REFERENCE F686 Based on interview and record review the facility failed to ensure the care plan was revised when the resident developed a pressure injury (PI- skin injury from prolonged pressure on the skin and tissue underneath) on the inferior fold left buttocks area for one of five sampled residents (Resident 50). This deficient practice resulted in a delay in developing a person- centered care plan that could prevent a Stage 1 (intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness) pressure injury from progressing to a Stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) pressure injury. Findings: During a review of Resident 50's Admission Record, the Admission Record indicated Resident 50 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty in swallowing), paroxysmal atrial fibrillation (a type of irregular heartbeat, or arrhythmia), and unspecified dementia with other behavioral disturbance (progressive disease that destroys memory and other important mental functions). During a review of Resident 50's Minimum Data Set (MDS, a resident assessment tool) dated 5/23/2024, the MDS indicated the resident was unable to express ideas and wants or unable to understand others with short-term and long-term memory problem. The MDS indicated the resident was dependent on the staff with bathing, toileting hygiene, dressing, personal hygiene, oral hygiene, and transfer to and from the bed to a chair. The MDS indicated the resident had no pressure injuries. During a concurrent interview with Treatment Nurse (TN) 2 on 11/11/2024 at 2:45 p.m., and record review of the non-pressure ulcer weekly progress notes dated 6/18/2024 at 4:26 p.m., TN2 stated that Resident 50's pressure ulcer on the left buttock was with full thickness tissue loss in wound bed, visible deep open wound with subcutaneous fat exposed and surrounding erythema noted in wound edges mild serous drainage observed in old dressing. TN2 stated that the plan of care for Resident 50's pressure injury was initiated when it was a Stage 1 pressure injury. TN22 stated Resident 50's pressure injury care plan was not updated when Resident 50's pressure injury progressed to a stage 3, and further to a stage 4. TN2 stated that she never updated or revised the interventions. During an interview on 11/13/2024 at 3:46 p.m., with the Director of Nursing (DON), the DON stated she expects nurses to update the plan of care or initiate a care plan if there are changes to Residents current condition. The DON stated there was no care plan developed that would address the current Stage 4 pressure injury for Resident 50. The DON added that the IDT meet quarterly or annually only not when Resident 50 developed the Stage 1 pressure injury that progressed to a Stage 4. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's policy and procedure (P&P) titled care plans, comprehensive person-centered dated 12/2016, the P&P indicated a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on observation, interview and record review, the facility failed to prevent the development of a pressure injury (skin breakdown from prolonged pressure on the skin and tissue underneath) on the inferior (lower) fold of the left buttock area for one of five sampled residents (Resident 50) by failing to: a.Ensure Resident 50 was repositioned every two hours, as indicated in the care plan titled Skin Condition, to relieve the pressure off the left buttocks area. b.Ensure the Registered Dietician (RD) assessed Resident 50's nutritional status on 6/5/2024, when Resident 50 developed a Stage 1 pressure injury (intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness), on 6/10/2024 when the pressure injury progressed to a Stage 3, (full-thickness loss of skin, dead and black tissue may be visible), and again on 6/18/2024 when the pressure injury advanced to a stage 4 pressure injury (full thickness skin and tissue damage, where the wound exposes underlying structures including the bone). c.Ensure Resident 50's care plan titled Skin Condition was updated and interventions implemented to prevent a Stage 1 pressure injury from progressing to a Stage 4 pressure injury. d.Ensure Resident 50's Braden scale (a tool developed for early identification of patients at risk for forming pressure injuries) was updated after the resident developed a stage 1 pressure injury to the inferior fold left buttock and as it worsened to Stage 3 and then a stage 4. e.Ensure a change of condition (COC - a form used when a patient's clinical condition suddenly changes from the baseline) was completed when Resident 50 developed a Stage 1, stage 3, or stage 4 pressure injury to the inferior fold of the left buttock. f.Follow the facility's Policy and Procedure (P&P), titled Pressure Injuries/Skin Breakdown- Clinical Protocol which indicated the facility will assess and document an individual's significant risk factors for developing pressure sores. These deficient practices resulted in Resident 50 developing a stage 1 Pressure Ulcer on 6/5/2024, to the inferior fold left buttock, which progressed to a stage 4, on 6/18/2024 (13 days later) and caused Resident 50 to be in pain. Findings: During a review of Resident 50's Admission Record, the Admission Record indicated Resident 50 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty in swallowing), paroxysmal atrial fibrillation (a type of irregularly fast heartbeat, or arrhythmia), and unspecified dementia with other behavioral disturbance (progressive disease that destroys memory and other important mental functions). (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 50's Minimum Data Set (MDS, a resident assessment tool) dated 5/23/2024, the MDS indicated the resident was unable express ideas and wants or unable to understand others. The MDS indicated the resident was dependent on the staff with bathing, toileting hygiene, dressing, personal hygiene, oral hygiene, and transfer to and from the bed to a chair. The MDS indicated Resident 50 had no pressure injuries at the time of assessment on 5/23/2024. During a record review of Resident 50's Admission Pressure and Non-Pressure Injury Risk assessment dated [DATE], the Admission, Pressure and Non-pressure Injury Risk Assessment indicated Resident 50 scored 14 which indicated a moderate risk for developing pressure injuries. During a record review of Resident 50's Progress Notes dated 6/5/2024, the Progress Notes indicated CNA (identity was not specified) reported that Resident 50 had redness in the left buttock area. The Progress Notes indicated an assessment was done, a non-blanchable (skin that doesn't fade when pressure is applied to it indicating bleeding under the skin) redness in the inferior fold of the left buttock measuring 2.5 centimeters ([cm] unit of measurement) cm x 3cm was noted, skin intact, mild erythema (abnormal redness) noted in surrounding skin. The Progress Notes indicated the Resident reported feeling pain by expressing ouch when the area was palpated (examined by touch). The Progress Notes indicated to continue monitoring for skin breakdown and adjust treatment plan as needed. During a record review of Resident 50's progress notes titled Wound Visit Progress Notes and dated 6/17/2024, the notes indicated left gluteal (buttock) tissue with slough (dead tissue that is usually yellow, tan, gray, or green in color, usually moist and stringy in texture, that may be found in wounds), moderate drainage (fluid that comes out of a wound), muscle tissue noted or visualized. During an observation on 11/9/2024 at 8:16 a.m., Resident 50 was observed in bed laying on her back. During an interview on 11/9/2024 at 9:43 a.m., with Certified Nurse Assistant (CNA 1), CNA 1 stated Resident 50 will be staying in bed the whole day because she was expecting visitors. CNA 1 stated she did not recall when she last repositioned the resident and she did not document that she repositioned the resident. During an observation on 11/9/2024 at 11:01 a.m., Resident 50 was laying on her back, three hours and 15 minutes after Resident 50 was last observed laying on her back. During an observation on 11/10/2024 at 10:08 a.m., Resident 50 was in her bed laying on her back. During an interview on 11/11/2024 at 10:45 a.m., with Treatment Nurse 2 (TN 2). TN 2 stated she only did a Braden scale assessment when the resident is first admitted to create a baseline. TN 2 stated charge nurses did not follow up when residents of the facility developed new pressure injuries. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055539	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/11/2024 at 1:15 p.m., with the Minimum Data Set Nurse (MDSN), the MDSN stated she performed residents' Braden scale assessment quarterly. The MDSN stated TN 2 was responsible for initiating and updating Resident 50's care plan titled Skin Condition if there were any skin changes, or the resident developed a pressure injury. The MDSN stated assessments were important for identifying if a resident was a high risk for skin breakdown, so the facility could prevent the resident from acquiring pressure injuries, by initiating a person-centered plan of care based on the assessment. The MDSN stated she did not update Resident 50's care plan titled Skin Condition when the resident's pressure injury worsened from a stage 1 to a Stage 4. During a concurrent interview and record review on 11/11/2024 at 2:00 p.m., with the Registered Dietician (RD), Resident 50's Nutritional Assessment was reviewed. The RD stated that the nutritional status and needs of residents with pressure injury should be monitored closely since nutrition helps in wound healing. The RD stated that there was no nutritional assessment done and there were no recorded weights for Resident 50 for the month of June. The RD stated there was no Interdisciplinary team meeting (IDT-resident's healthcare team consisting of various specialties) conducted regarding Resident 50's facility acquired pressure injury, and nutrition. The RD stated Resident 50's nutritional status was not monitored. The RD stated that it was important to monitor resident's nutrition to aid in wound healing. During a concurrent interview and record review on 11/11/2024 at 3:14 p.m., with TN 2, Resident 50's, progress notes dated 6/5/2024, 6/7/2024, 6/10/2024, and 6/12/2024 were reviewed. TN 2 stated according to the progress notes: a. On 6/5/2024 a CNA reported that Resident 50 developed a stage 1 pressure ulcer in the left inferior fold of the buttock measuring 2.5 cm. x 3 cm. b. On 6/7/2024 TN 2 informed the Medical Doctor (MD) that Resident 50's stage 1 pressure injury had progressed to a stage 2. c. On 6/10/2024 at 3:41 p.m., Resident 50's wound had an irregular shape, with visible yellowish subcutaneous (tissue under skin) fat tissue stage 3, measuring 2.5 cm x 3 cm x 0.3 cm depth. d. On 6/12/2024, Resident 50's stage 2 pressure injury had progressed to a Stage 4, and had full thickness tissue loss with exposed bone and a black appearance measuring 0.5 cm in depth. During a record review of Resident 50's wound visit progress notes dated 6/17/2024, the notes indicated Resident 50's left gluteal tissue had slough (dead tissue that is usually yellow or green in color), moderate drainage (fluid from the wound), with visible muscle tissue. During a concurrent interview and record review with TN 2 on 11/11/2024 at 3:23 p.m., Resident 50's care plan, titled Skin Condition dated 6/5/2024 was reviewed. TN 2 stated the care plan interventions indicated staff will encourage and assist Resident 50 to turn every 2 hours and encourage the resident to be up and out of bed daily. TN 2 stated as Resident 50's pressure injury worsened from a stage 1 to a stage 4 she did not update the care plan. During a concurrent observation and interview on 11/12/2024 at 11:50 a.m., with TN 2, Resident 50's was lying in bed, on her back. TN 2 stated Resident 50 would be staying in her bed all day because she would be getting visitors. (continued on next page)

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	055539	A. Building B. Wing	11/15/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/13/2024 at 1:12 p.m., with the Director of Nursing (DON), the DON stated it was not the facility's practice to do a COC and update the Braden scale assessment if there was a pressure injury acquired in the facility. The DON stated TN 2 was expected to do an Event charting or observations when changes occurred with a resident. The DON stated licensed staff did not subsequently monitor the resident for 72 hours and did not need to document their observations. The DON stated the care plan should have been updated each time the pressure injury deteriorated. The DON stated this was not done for Resident 50. During a review of a Portable Document Format (PDF) published by the National Pressure Injury Prevention Advisory Panel, titled Pressure Injury Prevention Points, dated 2020, the PDF indicated the following pressure injury prevention points: 1.Consider bedfast and chairfast individuals to be at risk for development of pressure injury. 2.Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface. 3.Turn and reposition all individuals at risk for pressure injury, unless contraindicated due to medical condition or medical treatments. 4.Continue to reposition an individual when placed on any support surface. 5.Reposition weak or immobile individuals in chairs hourly (www.npiap.com) During a record review of the facility's policy and procedure (P&P) titled Pressure Injuries/Skin Breakdown-Clinical protocol dated 03/2024, the P & P indicated the nursing staff and attending physician will assess and document an individual's significant risk factors for developing pressure sores, for example immobility, recent weight loss and a history of pressure injury. Nutritional supplementation should be based on realistic appraisal of need and identification of medical conditions and factors that affect appetite, weight, and overall nutritional balance. During a record review of the P&P titles Change in a Resident's condition or status dated 12/2016, the P&P indicated regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatment, the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 41) with limited range of motion (ROM - the extent of movement of a joint) and/or limited mobility, received appropriate treatment and services to increase ROM, prevent decline in ROM, prevent further decline in ROM, and maintain mobility and/or improve mobility by failing to: 1. Ensure Resident 41 received ROM exercises on his upper bilateral (both) extremities as indicated in the facility's policy. Resident 41 was receiving ROM only on his lower bilateral extremities. 2. Ensure a physician's order for the application of a left-hand splint (a device that stabilizes a body part to protect it from further injury and help it heal) was followed as ordered. Resident 41 was observed to have a towel roll in the left hand. This deficient practice had the potential to place Resident 41 at risk for further ROM decline and contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). Findings 1.During a review of Resident 41's Admission Record, the Admission Record indicated Resident 41 was admitted on [DATE] with the diagnoses including dementia (a progressive state of decline in mental abilities). During a review of Resident 41's Minimum Data Set (MDS - a resident assessment tool) dated 10/1/2024, the MDS indicated Resident 41's cognition (ability to make decisions of daily living) was severely impaired, and Resident 41 was dependent on facility staff to complete activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 41's untitled care plan related to Resident 41 requiring staff assistance for functional abilities with self -care and physical mobilities start date of 10/5/2022 and revised on 10/16/2024, the care plan indicated a goal of Resident 41 increasing ADL independence in performing ADLs and having no pressure ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence) on bony prominence. The care plan indicated interventions including Restorative Nurse Assistant (RNA-provide skill practice in such activities as walking and mobility, dressing, and grooming, eating and swallowing, transferring, amputation care, and communication in order to improve and maintain function in physical abilities and ADLs and prevent further impairment) to provide bilateral lower extremity (BLE) active assist range of motion (AAROM-the range of movement a person can achieve when they receive partial assistance from an outside force) while Resident 41 is up in the chair seven days a week to patient tolerance. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 41's Rehabilitation Screening dated 8/23/2024, the Rehabilitation Screening indicated Resident 41 had minimal (less than 25%) ROM in the left wrist, moderate (25-50%) ROM in the left hand, and impairment that interferes with daily functioning on the left upper extremity. The Rehabilitation Screening indicated Resident 41 was under nursing custodial care with a history of advancing dementia and there were no needs for therapy at that time. During a review of Resident 41's Rehabilitation Screening dated 10/10/2024, the Rehabilitation Screening indicated Resident 41 ROM of bilateral upper extremities (BUE) is within functional limits except left hand is in flexion contracture (a bent joint that cannot be straightened) and continue patient on RNA program. The Rehabilitation Screening indicated Resident 41 had minimal (less than 25%) ROM in the left wrist, moderate (25-50%) ROM in the left hand, and impairment that interferes with daily functioning on the left upper extremity. The Rehabilitation Screening indicated Resident 41 was under nursing custodial care with a history of advancing dementia and there were no needs for therapy at that time. During a review of Resident 41's physician order dated 4/18/2023, the physician order indicated Resident 41 was to receive AAROM on BLE by RNA daily seven days a week. During an interview on 11/11/2024 at 2:29 p.m., with the Restorative Nurse Assistant 1 (RNA 1), RNA 1 stated she provides ROM on Resident 41's lower extremities. RNA 1 stated ROM is not required on Resident 41's upper extremities because he is able to move those extremities. 2. During an observation on 11/9/2024 at 9:33 a.m., of Resident 41 in his room, Resident 41 was observed lying in bed with a towel roll in his left hand. Above Resident 41's bed was a sign indicating nursing staff should ensure towel roll is always in Resident 41's left hand. During a review of Resident 41's physician order dated 4/17/2024, the physician order indicated Resident 41 should always have left hand splint in place with assessment of patient tolerance every hour. During a review of Resident 41's Rehabilitation Screening dated 3/29/2023, the Rehabilitation Screening indicated Resident 41 was referred for occupational therapy (OT- a healthcare provider who helps people improve their ability to perform daily tasks) screen due to contracture of left hand causing increased risk of pressure injury and difficultly with hand hygiene and nail care. The Rehabilitation Screening indicated Resident 41's left hand has severe contracture and may benefit from over the counter (OTC) air hand splint (inflatable) to reduce further contracture and promote metacarpophalangeal (MCP- where the finger bones meet the hand bones) extension to reduce risk of skin breakdown/infection. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent observation of Resident 41 on 11/12/2024 at 9:42 a.m., with the Director of Rehabilitation (DOR), the DOR assessed Resident 41's ROM on his upper left extremity and stated Resident 41 has stiffness of the muscle in the left hand, and Resident 41 would benefit from the use of a splint on the left hand. The DOR stated a towel roll is different from a hand splint. The DOR observed Resident 41's right hand, specifically the fifth and fourth digit, the DOR stated Resident 41 does not move those fingers and they are in a closed position. The DOR stated Resident 41's right upper extremity is at high risk to have limitation if there is no intervention to prevent or maintain the extremities ROM. The DOR stated Resident 41 does not have the cognitive skills to maintain joint mobility and prevent any contractures. The DOR stated Resident 41 would benefit from RNA ROM for bilateral upper extremities in order to maintain and prevent decline in ROM. During a review of facility's policy and procedure (P/P) titled Resident Mobility and Range of Motion dated 7/2017, the P/P indicated residents with limited range of motion and limited mobility will receive appropriate services to increase and/or prevent further decrease in ROM and will receive appropriate services, equipment, and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. During a review of facility's P/P titled Use of Splints for Residents undated, the P/P indicated splints should be applied in accordance with specific instructions provided, ensuring it is correctly positioned and not overly tight. The P/P indicated the nursing staff is responsible for applying and monitoring splints as per physician or therapist orders.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 210) was free of accidents when facility staff continued to use the stand-up lift (mobility equipment used to help a person transfer from a seated position to a standing position) to transfer Resident 210 to and from the bed despite Resident 210 exhibiting agitation and combativeness during use of the stand-up lift upon transfer. The deficient practice resulted in Resident 210 suffering a 1.5 centimeter (cm-unit of measurement) by 1.5 cm small bluish bump on the left side of her forehead sustained during the use of a stand-up lift. Findings: During a review of Resident 210's Admission Record, the Admission Record indicated Resident 210 was admitted on [DATE] with the diagnoses including pneumonia (an infection/inflammation in the lungs) and difficulty in walking. During a review of Resident 210's Minimum Data Set (MDS - a resident assessment tool) dated 9/3/2024, the MDS indicated Resident 210's cognition (the mental process involved in knowing, learning, and understanding things) was moderately impaired and Resident 210 required set up or clean up assistance (helper sets up and resident completes the activity) from facility staff when transferring from chair/bed to chair transfer. During a review of Resident 210's physician order dated 7/17/2024, the physician order indicated to monitor for episodes of agitation manifested by episodes of screaming/yelling for help and restlessness. During a review of Resident 210's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 7/2024, the MAR indicated on 7/27/2024 Resident 210 had five episodes of agitation manifested by episodes of screaming/ yelling for help and restlessness from 7 a.m. to 11 p.m. During a review of Resident 210's untitled care plan related to Resident 210 being at risk for bruising and/ or skin discoloration, the care plan indicated a goal for Resident 210 to have no episodes of bleeding and bruises though the next review (10/31/2024). The care plan indicated one intervention which was to handle Resident 210 gently when providing care. During a review of Resident 210's Progress Notes dated 7/27/2024, the Progress Note indicated Resident 210's RP noticed a small bump on Resident 210's forehead and reported it to the charge nurse. The Progress Note indicated the charge nurse assessed Resident 210 to have a small bump and bluish discoloration on the left side of Resident 210's forehead. The Progress Note indicated facility staff use a stand-up lift during transfer to and from the bed for Resident 210 and that may have possibly caused the injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's Post Incident (Non-Fall) Investigation Report dated 7/27/2024, the Post Incident (Non-Fall) Investigation Report indicated Resident 210's left side of her forehead had a bluish discoloration/bump that measured 1.5 cm by 1.5 cm. The Post Incident (Non-Fall) Investigation Report indicated the facility's concluded Resident 210 required the use of the stand-up lift, which Resident 210 does not like and causes her to become agitated, scream and yell. The Post Incident (Non-Fall) Investigation Report indicated Resident 210 possibly bumped the left side of her head on the sling hook on the stand-up lift or another part of the lift. During an interview on 11/11/2024 at 3:17 p.m., with Certified Nurse Assistant 4 (CNA 4), CNA 4 stated when a resident uses the stand-up lift, the facility staff will tell the resident to stand up as the machine is guiding the resident to the upright position. CNA 4 stated if the resident is not cooperative, then two people are required to use the stand-up lift, one person to hold/guide the resident's hands to hold the lift and the other person to operate the remote. During an interview on 11/13/2024 at 1:16 p.m., with the DON, the DON stated Resident 210 did not like the stand-up lift or any mechanical lift the facility staff would use for her, and she would scream when the facility staff would use the stand-up lift. The DON stated facility staff did not explore other methods to safely transfer Resident 210. The DON stated if an uncooperative resident is using the stand-up lift, they could let go resulting in an injury or a fall. The DON stated when Resident 210's RP reported the bluish discoloration and bump on the left side of her forehead, the DON assumed since Resident 210 was combative while using the stand lift, it could result in a bruise. During a review of the facility's policy and procedure (P/P) titled Assistive Devices and Equipment dated 7/2017, the P/P indicated one of the factors that will be addressed to the extent possible to decrease the risk of avoidable accidents associated with devices and equipment included appropriateness for resident's condition indicating the resident will be assessed for lower extremity strength, range of motion, balance and cognitive abilities when determining the safest use of devices and equipment.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on interview and record review the facility failed to: 1.Inform the physician (MD) of the abnormally low urine output (a measurement of how much urine a person produces) for one of one sampled resident (Resident 58), when Resident 58's urine output was 50 Cubic Centimeter (cc- a unit of measure of volume), (Reference Range of 280-560 cc for 8 hour) on 8/26/2024 during 7:00 a.m.- 3p.m. shift. 2. Initiate a change of condition (COC-tool used by health care professionals when a patient's condition suddenly changes) when Resident 58's urine output was observed to be 50 Cubic Centimeter on 8/26/2024 during 7:00 a.m.- 3p.m. shift. 2. Monitor Resident 58's urine output from 8/27/2024 to 9/13/2024 These deficient practices resulted in Resident 58 having signs and symptoms (S/S) of dehydration including sunken eyeballs, and dry lips was transferred to a General Acute Care Hospital (GACH) for evaluation and diagnosed with acute kidney injury likely due to prerenal azotemia (a high concentration of waste products in the blood due to dehydration). Resident 58 was admitted from 9/13/2024-9/24/2024 (a total of 11 days) for treatment. Findings: During a review of Resident 58's Admission Record, the Admission Record indicated Resident 58 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic kidney disease (a gradual loss of kidney function) and non-ST elevation (NSTEMI) myocardial infarction (heart attack). During a review of Resident 58's Minimum Data Set (MDS, a resident assessment tool) dated 8/26/2024, the MDS indicated the resident was able to express ideas and wants to others and usually understands others. The MDS indicated the resident was partially dependent on the staff with eating but totally dependent on staff for bathing, toileting hygiene and personal hygiene. Resident 58 needed substantial or maximal assistance with sit to lying, sit to stand, chair to bed transfer, toilet transfer and tub transfer. Resident 58 was taking diuretics during the last 7 days (of the MDS assessment look back time period) and had an indwelling catheter. During a record review of Resident 58's Physician Order report from 8/14/2024-9/30/2024, the Physician's Order Report indicated furosemide (a strong water pill that may cause dehydration and electrolyte imbalance) 20 milligram (mg- unit of measure of mass) twice daily for bilateral (both) lower extremity edema (excess fluid collecting in the tissues), black box warning (strict warning labels used when labeling medication) dehydration and electrolyte (minerals that have an electrical charge when dissolved in body fluids) depletion dated 8/14/2024. Indwelling catheter French16/10cc for diagnosis of urine retention dated 8/14/2024. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 11/9/2024 at 2:56 p.m., with the Assistant Director of Nursing (ADON), Resident's 58's progress notes monthly weight, intake, and output (I &O) and COC for the month of 08/2024-09/2024 were reviewed. The ADON stated the progress notes on 8/15/2024 indicated Resident 58 was admitted with dependent (a type of swelling that occurs when fluids build up in areas of the body below the heart) edema on both legs. The ADON stated the I & O dated 8/26/2024 indicated Resident 58's urine output for the 7-3 p.m. shift was 50 cc. The ADON stated the progress notes dated 9 /13/2024 at 11:31 a.m., indicated Resident 58 returned from her primary care physician's (PCP) appointment accompanied by a family member (FM 1) who was also her emergency contact, at approximately 9:47a.m. The ADON stated according to the progress notes FM 1 informed staff that Resident 58's PCP stated Resident 58 needed to go to the emergency room (ER). The ADON stated the progress notes indicated FM and Resident 58 returned to the facility to collect the resident's belongings. During a concurrent interview and record review on 11/9/2024 at 3:35 p.m., with the ADON, Resident 58's care plan titled Dehydration/fluid maintenance related to diuretic therapy for bilateral leg edema and CHF dated 8/21/2024, the ADON stated the care plan interventions included to assess for dehydration and electrolyte imbalance signs and symptom such as dizziness on sitting/standing, change in mental status, decreased urine output, poor skin turgor (skin's inability to return to normal after pinching, which is a sign of dehydration) dry mucus membrane (moist lining of some organs and body cavities), sunken eyes, and constipation (bowel movements that are infrequent, uncomfortable or difficult to pass, which may be a sign of dehydration). The ADON stated assessing Resident 58 for dehydration was an intervention in the care plan but there was no documentation to show that licensed nurses assessed and monitored Resident 58 for dehydration during any shift. The ADON stated when nurses see these signs and symptoms of dehydration such as low urine output, they should start documenting the signs and symptoms (S/S) and notify the MD that Resident 58 was had S/S of dehydration. The ADON stated when Resident 58's urine output was 50 cc over eight hours the MD was not notified. The ADON stated it was important to notify the MD for prompt interventions and to prevent the resident's condition from worsening. During an interview on 11/10/2024 at 2:17 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated monitoring a resident's I & O is to monitor for fluid retention, especially for Resident 58 who had CHF, which can cause fluid retention. LVN 3 stated that she was the one who documented that Resident 58 had 50 cc output of urine, during her shift on 8/26/2024. LVN 3 stated she did not initiate a COC, and she did not notify Resident 58's MD of the abnormal urine output. During a record review of Resident 50's emergency room (ER) Notes dated 9/13/2024, the ER Notes indicated Resident 58 had dry mucus membranes. The ER notes also indicated Resident 58's laboratory (medical diagnostic testing using blood samples) indicated the blood urea nitrogen, (BUN- a blood test for dehydration) was 44 (reference range 7-18mg/Deciliter [a unit of measure of fluid volume]). During a record review of Resident 58's Progress Notes on 9/14/2024 the GACH progress records indicated Resident 58's admitting diagnoses included acute kidney injury likely due to prerenal azotemia (a high concentration of waste products in the blood due to dehydration). The ER Notes indicated Resident 58 was dehydrated. (continued on next page)

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Artesia Christian Home Inc.	11614 E. 183rd St Artesia, CA 90701

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/13/2024 at 1:12 p.m., with the Director of Nursing (DON), the DON stated LVN 3 informed her that Resident 58's MD was not notified of Resident 58's S/S of dehydration. The DON stated if a resident's urine output is less than 100 cc, for the entire 8 hour shift, the MD should be notified and a COC initiated, to closely monitor the resident's intake and output. During a record review of the facility's policy and procedure (P&P) titled comprehensive Assessments and the care delivery process dated 12/2016, the P&P indicated comprehensive assessment, care planning and the care delivery process involved collecting and analyzing information, choosing, and initiating interventions, then monitoring results and adjusting interventions. During a record review of the facility's P&P titled Change in a Resident's condition or status dated 12/2016, the P&P indicated the nurse will notify the resident's attending physician or physician on call when there has been a need to alter the resident's medical treatment significantly and need to transfer the resident to a hospital/ treatment center.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on observation, interview and record review, the facility failed to ensure one of one dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) resident (Resident 6) had equipment and supplies necessary to manage dialysis emergencies such as bleeding. at the bedside. The deficient practice has the potential to result in complications from dialysis and bleeding. Findings: During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was originally admitted to the facility on [DATE] with diagnoses including muscle weakness, and end stage renal disease (ESRD -irreversible kidney failure), anemia (a condition where the body does not have enough healthy red blood cells), and dependence on renal dialysis. During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated 8/21/2024, the MDS indicated Resident 6's cognition was intact. The MDS indicated Resident 6 needed partial assistance when eating, with oral and personal hygiene, and was dependent on staff with showering and toileting hygiene. During a review of Resident 6's Physician Order Report dated 10/11/2024 to 11/11/2024, the report indicated, starting 8/9/2024, hemodialysis procedure a.m., due to ESRD. During an observation and interview on 11/10/2024 at 1:19 p.m., at Resident 6's room with Licensed Vocational Nurse (LVN) 3, Resident 6 did not have an emergency dialysis kit at the bedside. LVN 3 stated there was no emergency supplies at the bedside in case there was a dialysis emergency like bleeding. During an interview on 11/13/2024 at 3:50 p.m., with the Director of Nursing (DON), the DON stated the facility does not have a dialysis bleed kit at the bedside the nurses would have to grab whatever they can in case of an emergency. During a review of the facility's policy and procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident with revised 9/2010, the P&P indicated Residents with ESRD will be cared for according to currently recognized standards of care. The P&P indicated staff will recognize and intervene in medical emergencies such as hemorrhages. Apply constant pressure to site and call 911.

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 44055 Based on observation, interview, and record review the facility failed to ensure the psychiatrist's (medical practitioner specializing in the diagnosis and treatment of mental illness) services were provided to residents who were receiving psychotropic (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) medication for four out of six sampled residents (Residents 2, 17, 19, and 51). Resident 2 had a diagnosis of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and Residents 17, 19, and 51 had diagnoses of dementia (a progressive state of decline in mental abilities), The facility failed to: 1. Ensure Residents 2, 17, 19, and 51, who were being treated with psychotropic medications including Cymbalta (a drug used to treat depression), Ativan (drug that is used to treat anxiety [feeling of fear, dread, and uneasiness]), Seroquel an antipsychotic (a class of drugs used to treat symptoms of psychosis [a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), Depakote (a medication used to treat manic episodes - emotional highs- associated with bipolar disorder [bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs]), Mirtazapine (medication to treat depression), Haloperidol (a high potency drug used to treat certain mental and neurological disorders), and Donepezil (a medication that treats symptoms of dementia like memory loss and confusion), were evaluated by a psychiatrist for the appropriateness of psychotropic medication use before starting the psychotropic medication regimen during use of psychotropic medications, and as needed. 2. Ensure Residents 2's medication regimen therapy with Cymbalta 30 milligrams ([mg] a unit of weigh measurement), that started on 4/23/2024, twice a day for depression, was evaluated by a psychiatrist to assess for appropriateness, effectiveness, and the need to increase or decrease medication dosage to ensure the resident's safety, and that Resident 2 reached the highest practicable quality of life. Resident 2 was admitted on [DATE] and has been taking psychotropic medications since admission. Resident 2 had not been evaluated by a psychiatrist since 2/28/2023. 3. Ensure Resident 17's psychotropic medication regimen was evaluated by a psychiatrist to assess the effectiveness of the psychotropic medications and the need to increase or decrease the dosage to ensure Resident 17 reached the highest practicable quality of life. Resident 17's medication regimen included: a. a. Cymbalta, 30 mg which Resident 17 started taking once a day, on 11/1/2024. b. Ativan 0.5 mg, which Resident 17 started taking twice a day on 9/14/2022. c. Seroquel 50 mg, which Resident 17 started taking every 12 hours on 6/2/2023 for bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	d. Depakote 250 mg, which Resident 17 started taking twice a day on 11/2/2024, 250 mg. 4. Ensure Resident 19's medication regimen therapy was evaluated by a psychiatrist to assess the effectiveness of the psychotropic medications and the need to increase or decrease the dosage to ensure Resident 19 reached the highest practicable quality of life. Resident 19 was admitted on [DATE] and has not been evaluated by a psychiatrist for being on psychotropics since admission. Resident 19's medication regimen included: a. Ativan 0.5 mg, which Resident 19 started taking every 12 hours on 5/14/2024. b. Mirtazapine 7.5 mg, which Resident 19 started taking every night starting on 10/17/2023. c. Seroquel 25 mg, which Resident 19 started taking every day on 12/14/2023, for dementia with agitation. 5. Ensure Resident 51's medication regimen therapy was assessed by a psychiatrist for effectiveness and the need to increase or decrease dosage so Resident 51 reached the highest practicable quality of life. Resident 51 was admitted on psychotropics since 12/19/2023 and has not been evaluated by a psychiatrist. A psychiatrist consult had been ordered on 7/23/2024 but as of 11/14/2024 Resident 51 have not been evaluated by a psychiatrist. Resident 51's was taking the following medication regimen included: a. Haloperidol 5 mg, which Resident 51 started taking every 12 hours on 10/2/2024, every 12 hours for psychosis. b. Seroquel 50 mg, which Resident 51 started taking twice a day, on 7/17/2024. c. Donepezil 5 mg which Resident 51started taking daily on 12/19/2023. 6. Ensure a psychiatrist was part of the Interdisciplinary team ([IDT] a resident's healthcare team consisting of various specialties who work together to provide care for a patient) meetings to evaluate the residents' behavior and use of psychotropic medication, and plan the care accordingly for Residents 2, 17, 19, and 51 regarding the need and appropriateness of a gradual dose reduction ([GDR] - the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the medication can be discontinued altogether) of psychotropic medications. 7. Ensure staff followed the facility's policy and procedure (P/P) titled, Dementia Care Manual indicating residents who have reoccurring behavioral disturbances should be routinely seen and reevaluated by a psychiatrist. 8. Ensure staff followed the facility's P/P titled, Antipsychotic Medication Use indicating antipsychotic medication will be prescribed at the lowest possible dosage for a short period of time and are subject to GDR and re-review. Residents will only receive antipsychotics medications when necessary to treat specific conditions for which they are indicated and effective. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	9. Ensure staff followed the facility's P/P titled, Behavioral Assessment, Intervention and Monitoring dated 12/2016, that indicated the facility will comply with regulatory requirements related to the use of medications to manage behavioral changes. 10. Ensure staff implemented the Facility Assessment (a review of the facility's needed resources and capabilities to provide care for its residents), reviewed 10/16/2024, which indicated the facility resources needed to provide competent support and care for the resident population every day and during emergencies- under Therapy services - Psychology Services and Behavioral Health Services as indicated. These deficient practices placed Residents 2, 17, 19, and 51 at high risk for receiving unnecessary psychotropic medication, experiencing the potential side effects associated with the use of these medications, and not to have behavioral symptoms under control. The potential side effect of psychotropic medications included but are not limited to the following: a. Ativan: drowsiness and confusion. b. Haloperidol: difficulty speaking/swallowing, loss of balance, muscle spasms, and extrapyramidal symptoms (EPS - motor problems that include Parkinsonian-like symptoms (stiffness, tremor, shuffling gait), acute dystonia (abrupt spasms of head and neck), and akathisia (physical restlessness). c. Seroquel: increased mortality (death) in elderly patients with dementia, chills, confusion, and dizziness. d. Depakote: confusion, crying, delusions (altered reality that is persistently held despite evidence or agreement to the contrary) of persecution, mistrust, and combativeness. e. Cymbalta: body aches, cough, constipation (bowel dysfunction that makes it difficult or infrequent to have a bowel movement), and dry mouth. f. Donepezil: diarrhea, loss of appetite, and trouble sleeping. g. Mirtazapine: dizziness and drowsiness On 11/14/2024 at 1:16 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation has cause, or is likely to cause, serious injury, harm impairment or death to a resident) situation due to the facility's failure to obtain psychiatric services for Residents 2, 17, 19, and 51 was called in the presence of Administrator (ADM) and the Director of Nursing (DON). On 11/16/2024 at 6:48 p.m., the IJ was removed in the presence of the DON after the facility submitted an acceptable IJ Removal Plan ([IJRP] - interventions to correct the immediacy of the deficient practices) and the IJRP implementation was verified through observation, interview, and record review. The IJRP included the following immediate actions: (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Residents 2, 17, 19 and 51 will be evaluated on 11/18/2024, by a psychiatrist and to be completed by end of the day on 11/21/2024. Following these evaluations, ongoing monthly psychiatric services will take place for these residents. In addition, evaluations and routine psychiatric services will be completed for residents with psychiatric diagnosis upon admission, thereafter, and as needed by a Psychiatrist. The facility will have a monthly Behavioral Intervention Treatment meeting where we will discuss and review any residents on a psychotropic medication and any recommendations will be discussed at this meeting. Those who will attend the meeting will include the Licensed Psychiatrist and the Licensed Pharmacist. Any Resident with a behavioral change in condition (increased behaviors or new behavior) will be placed on a 72-hour change of condition monitoring using the facilities matrix (a grid-like tool used to organize and analyze data about a healthcare facility) event titled Behavior Log. 2. On 11/14/2024 all licensed nurses, which included the Interdisciplinary team (IDT) members, the DON, the Assistant Director of Nursing (ADON), the Associate Director of Social Services (ADSS) and the Minimum Data Set (MDS) coordinator, working on the 7-3 & 3-11 shifts were in-serviced immediately on psychiatric diagnosis and the need for a psychologist or psychiatrist consult for residents on psychotropic medication. The Director of Staff Development (DSD) will do another in-service tomorrow morning on 11/15/2024 for those that were not here today. The DSD has a list of those on leave, vacation or who were not able to attend and when they are back on schedule will set a date for an Inservice as well. 3. The facility will ensure they will be able to meet the needs of residents who are admitted with psychiatric or behavioral needs based off the recently updated Facility Assessment (a review of the facility's needed resources and capabilities to provide care for its residents) revised on 11/14/2024. 4. The facility added Psychiatric Services to the Facility Assessment as we have obtained a psychiatric services company to evaluate those with psychiatric diagnoses and to assess the effectiveness and the need to increase or decrease medication dosage to ensure resident's safety and symptoms are under control. If the facility is unable to meet the needs of any resident, the ADSS will initiate the discharge planning process. Currently there are no residents whose needs we cannot meet. 5. The facility will ensure that a Psychiatrist/Psychiatric Nurse Practitioner participates in the monthly Behavioral Intervention Treatment meeting for those residents receiving psychotropic medications. The Psychiatrist/Psychiatric Nurse Practitioner will make routine rounding visits to assess the effectiveness and the need to increase or decrease medication dosage to ensure resident's safety and symptoms are under control. On these rounding monthly Behavioral Intervention Treatment meetings the team (Administrator, DON, ADON, ADSS, MDS Coordinator, DSD, Licensed contracted Pharmacist, and the Board-Certified Psychiatric Nurse Practitioner) will meet to discuss any recommendations and carry out any recommendations from those visits. 6. The facility's DON will monitor the current number of residents on psychotropic medications to ensure that every resident with psychotropic medications is receiving psychiatric services monthly. The Associate Director of Social Services/SSD will report the number of residents and visits to the facilities Quality Assurance Performance Improvement quarterly monitoring meetings with a threshold of 100% through November 2025. Findings: (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was admitted to the facility on [DATE] with diagnoses including dementia with other behavioral disturbance, bipolar disorder generalized anxiety disorder (mental health condition that causes people to experience excessive and uncontrollable worry about everyday events or activities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), abnormalities of gait and mobility. During a review of Resident 17's Minimum Data Set ([MDS] - a resident assessment tool), dated 10/3/2024, the MDS indicated Resident 17's cognition (the mental process of thinking, understanding, and processing information) was severely impaired. The MDS indicated the resident was independent when eating, needed set up assist with oral hygiene, needed moderate assist (helper does less than half the effort) with personal hygiene, needed maximal assistance (helper does more than half the effort) with showering, and was dependent on staff with toileting hygiene. The MDS indicated the resident was on antipsychotic medications since admission. The MDS also indicated a GDR had not been attempted and the physician had not documented a GDR was clinically contraindicated (a reason for a person to not receive a particular treatment or procedure because it may be harmful). During a review of Resident 17's Physician's Order Report dated 11/1/2024 - 11/10/2024, the Physician's Order Report indicated the following orders: a. Starting 6/27/2019, monitor for episodes of agitation that interfere with care, every shift, for use of Ativan. b. Starting 6/27/2019, monitor for restlessness that interfere with care, every shift, for use of Ativan. c. Starting 6/27/2019, monitor for side effects of anti-anxiety medication use Ativan. - Observe resident closely for significant side effects: sedation, drowsiness, ataxia (drunk walk), dizziness, nausea, vomiting, confusion, headache, blurred vision (a loss of sharpness in your vision that makes it difficult to see fine details), skin rash. d. Starting 6/27/2019, monitor for side effects of antipsychotic medication use Seroquel - Edema (swelling caused by fluid building up in the body's tissues), postural hypotension (medical condition that causes a drop in blood pressure when you stand up or sit down), sweating, loss of appetite, urinary retention (a condition that makes it difficult to empty the bladder, either partially or completely). Special attention for tardive dyskinesia (a movement disorder caused by the long term use of antipsychotics that causes involuntary, jerky movements in the face and body), seizure disorder (chronic brain problem causing sudden burst of electric activity in the brain), chronic constipation (a common condition that involves infrequent or difficult bowel movements), glaucoma (group of eye diseases that can damage the optic nerve, leading to vision loss and blindness), diabetes (group of diseases that result in too much sugar in the blood), skin pigmentation (refers to color of skin changing), jaundice (condition that causes the skin eyes, and mucous membranes to turn yellow or greenish)every shift. e. Starting 9/14/2022, Ativan. 0.5 mg twice a day, for anxiety manifested by restlessness or agitation that interferes with care, monitor for signs and symptoms of respiratory depression/sedation. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 11/12/2024 at 2:54 p.m., with Certified Nurse Assistant (CNA 3), by the door of Resident 17's room, Resident 17 was sleeping in her wheelchair. CNA 3 looked at Resident 17 and stated Resident 17 usually dozed off and falls asleep in her wheelchair, so the staff put her back in bed. During a phone interview on 11/13/2024 at 7:49 a.m., with the Licensed Pharmacist (LP), the LP stated that drooling or excessive salivation can be a side effect of psychotropic use. The LP stated psychotropic use was worse for elderly and even worse for dementia residents. The LP stated inappropriate psychotropic use can cause falls and can cause residents to be drowsy or sedated (falling asleep as a side effect of a drug). During an interview and record review on 11/13/2024 at 9 a.m., with the ADON, Resident 17's Behavior Quarterly Management Follow up, dated 7/3/2024, was reviewed. The ADON confirmed and stated Resident 17 was on Lorazepam 0.5 mg twice a day for anxiety manifested by episodes of restlessness or agitation that interferes with care. The Behavior Quarterly Management Follow up indicated for the month of January 2024, Resident 17 had zero episodes of restlessness and one episode of agitation. For the month of February 2024, Resident 17 had 4 episodes of restlessness and 3 episodes of agitation. For the months of March and April 2024 Resident 17 had no episodes of agitation and restlessness. The ADON stated Resident 17 was on Seroquel 50 mg every 12 hours for bipolar disorder, depressive type manifested by easily gets irritated or gets angry and suspicious of anything you say, that interferes with care. The ADON stated during the months of January, February and March 2024 Resident 17 had behaviors of easily getting irritated and paranoia, and in the month of April 2024 the resident had zero behaviors manifested. The ADON stated, Seroquel was increased last year to every 12 hours on 6/2/2023, the IDT team decided to continue the current psychotropic regimen because the benefits outweighed the risks for reduction. The ADON stated the physician was not contacted because the IDT team had decided there were no pharmacological (medication) adjustment required. The form indicated there was no physician signature indicating the physician or a psychiatrist was consulted with IDT decision to not complete the GDR and Resident 17 continue to receive the same medication at the same dose. 2. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including major depressive disorder, spondylolysis lumbar region (age-related change of the back bones), and history of falling. During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident was understandable and was able to understand others. The MDS indicated the resident was on setup or clean up assistance for eating and oral hygiene and dependent (helper does all the effort) on the staff for bathing, toileting hygiene, and transfer to and from the bed to a chair. During a record review of Resident 2's Physician's Order for Paroxetine (medication to treat depression), the order indicated Paroxetine was ordered for management of depression manifested by crying and verbalization of loneliness since admission 2/28/2023 and discontinued on 4/16/2024. During a review of Resident 2's Physician's Order Report dated 10/12/2024 - 11/12/2024, the Physician's Order Report indicated the following orders: a. Starting 4/23/2024, monitor episodes of crying every shift for Cymbalta. b. Starting 4/23/2024, monitor verbalizing loneliness every shift for Cymbalta. (continued on next page)

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	11/15/2024

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

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	c. Staring 4/23/2024, Cymbalta delayed capsule release 30 mg oral for chronic musculoskeletal (having to do with muscles, bones, tendons, ligaments, joints, and cartilage) pain and depression manifested by crying and verbalizing loneliness. During an interview and record review on 11/12/2024 at 9:30 a.m., with the ADON, Resident 2's Copy of Behavior Quarterly Management Follow up, dated 7/3/2024 and timed at 5:56 p.m., was reviewed. The Copy of Behavior Quarterly Management Follow up indicated Paroxetine was discontinued and Cymbalta was added for both pain and management of depression manifested by crying and verbalization of loneliness. The ADON stated the Paroxetine had been ordered for Resident 2 upon admission to the facility on [DATE] for major depressive disorder. The ADON stated Resident 2 has never been seen by a psychiatrist for management of Resident 2's psychiatric diagnosis of depression. The ADON stated Resident 2 has never had a psychiatric consult while in the facility for depression and while being on psychotropic medication. During an interview on 11/12/2024 at 2:35 p.m., with the ADSS, the ADSS stated the need for a medication dose adjustment was decided by the IDT team consist of the DON, the ADON, MDS coordinator, the Registered Dietician (RD), and the ADSS. After IDT makes determination, the physician then contacted to write the order. During an interview and record review on 11/13/2024 at 10:20 a.m., Resident 2's Behavior Quarterly Management Follow up, dated 9/20/2024 was reviewed and the ADON confirmed and stated the resident was doing well (not having behaviors) so the IDT team decided no pharmacologic changes in dose were needed for this quarter. The ADON stated the IDT team only called and notified the physician if the IDT team recommended a medication dose adjustment or need for more pharmacological measures. 3. During a review of Resident 19's Admission record, the Admission Record indicated Resident 19 was admitted on [DATE] with diagnoses including dementia with agitation. During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19's cognition was severely impaired. The MDS indicated Resident 19 was dependent on facility staff to complete activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated the resident was routinely on antipsychotic medications since admission. Resident 19 was on During a review of Resident 19's Physician's Order Report dated 10/11/2024 - 11/11/2024, the Physician's Order report indicated. a. Starting 10/17/2023, monitor combativeness every shift for Seroquel. b. Starting 10/17/2023, monitor for continuous screaming that interferes with care every shift for Seroquel. c. Starting 10/17/2023, monitor for side effects of antipsychotic medication use (Seroquel) - Observe closely for significant side effects: Common - sedation, drowsiness, dry mouth, constipation, blurred vision, extrapyramidal reaction, weight gain, edema, postural hypotension, sweating, loss of appetite, and urinary retention. Special attention for tardive dyskinesia, seizure disorder, chronic constipation, glaucoma, diabetes, skin pigmentation, jaundice every shift. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	d. Starting 10/17/2023, Mirtazapine 7.5 mg at bedtime for depression. e. Starting 12/14/2023, Seroquel 25 mg, oral, once a day, for dementia moderate agitation manifested by combativeness and continuous screaming that interferes with care. Increased mortality in elderly patients. f. Starting 5/14/2024, Ativan 0.5 mg oral, for anxiety manifested by inability to express what she wants and ending up yelling out and crying, every 12 hours. g. Starting 5/15/2024, monitor for unable to express what she wants and end up yelling out and cry, every shift, for Ativan. h. Starting 5/14/2024, monitor for side effects every shift of anti-anxiety medication use Ativan - Observe resident closely for significant side effects: sedation, drowsiness, ataxia (drunk walk), dizziness, nausea, vomiting, confusion, headache, blurred vision, skin rash: special attention if given with other sedatives hypnotics (a prescription medication that slows brain activity to calm a person down, relieve anxiety, or help them sleep), or alcohol. During an interview and record review on 11/12/2024 at 1:39 p.m., with the ADON, Resident 19's View Safety Alert Acknowledgement for Seroquel was reviewed. The View Safety Alert Acknowledgement Alert indicated a Black Box warning (the most serious warning that the U.S. Food and Drug Administration - [FDA] - can issue for a medication used to inform health care providers and consumers about serious adverse reactions or risks associated with a drug) indicating Seroquel should be used with extreme caution with patients with senile dementia (diseases related old age) The ADON stated Resident 19 was admitted to the facility with a diagnosis of dementia with agitation and Resident 19 had been on Seroquel. The ADON stated she overrode the Acknowledgement, and she did not select a reason for the override of the Alert. The order for Seroquel, dated 12/14/2023, was also reviewed and the warning of the View Safety Alert indicated an increased mortality in elderly residents. The ADON stated the Black Box warnings and Safety Alerts on medications were supposed to be reviewed because the Alerts indicated that there was increased risk for harm for the residents taking the medication mentioned in the Alert. During an interview and record review on 11/12/2024 at 1:39 p.m., with the ADON, Resident 19's Behavior Quarterly Management Follow Up, dated 10/31/2024 and timed at 7:51 a.m., was reviewed. The Behavior Quarterly Management Follow Up indicated Seroquel was increased on 12/14/2023, Ativan was changed from PRN (given as needed or requested) to being administerd every 12 hours on 5/14/2024, and Mirtazapine was continued. The ADON stated Resident 19 was on three psychotropics concurrently and Resident 19 had never had an assessment by a psychiatrist to evaluate the need for psychotropic medication since she has been in the facility. 4. During a review of Resident 51's Admission Record, the Admission Record indicated Resident 51 was admitted to the facility on [DATE] with diagnoses including dementia with psychotic (set of symptoms that indicate a loss of touch of reality) disturbance, and anxiety disorder. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 51's MDS, dated [DATE], the MDS indicated the resident's cognition was severely impaired. The MDS indicated Resident 51 was dependent on staff with bathing, toileting hygiene, dressing, personal hygiene, oral hygiene, and transfer to and from the bed to a chair. The MDS indicated Resident 51 was routinely on antipsychotic medications since admission. The MDS also indicated a GDR had not been attempted. During a review of Resident 51's Physician's order Report (active orders) dated 10/12/2024 - 11/12/2024, the Physician's order Report indicated the following orders: a. Starting on 12/19/2023, Donepezil (medication to treat dementia), oral, 5 mg, once a day. b. Starting on 7/11/2024, monitor for behavior of continuous yelling out that interferes with care every shift. c. Starting on 7/11/2024, monitor behavior of resisting care every shift. d. Starting on 7/17/2024, Seroquel 50 mg, oral, twice a day for dementia with agitation. e. Starting on 7/20/2024, Ativan 0.5 milligrams oral, every 12 hours as needed for anxiety manifested by constantly yelling that interfere with self and other residents. The order was discontinued on 9/23/2024. During review of physician's order dated 7/23/2024, the order indicated a psychiatric consult for Resident 51. During a review of Resident 51's Progress Notes, the Progress Notes indicated the following: a. On 7/23/2024 at 12:46 p.m., order received for psychiatric consultation due to continuous yelling out. b. On 7/29/2024 at 11:12 a.m., Resident 51 continued the constant disruptive yelling for 18-20 hours a day, causing multiple other residents (unidentified) to have agitative disruptive behaviors as well. Resident 51 was yelling so much Resident 51 would not eat, or drink fluids and this distressing behavior was attributing to her continued weight loss. Resident 51 was inconsolable and not redirectable. c. On 7/29/2024 the Progress Notes indicated a new order from MD 1 for Haloperidol 2.5 mg oral every 12 hours. During a review of Resident 51's physician's order dated 7/29/2024 at 11:09 a.m., the order indicated Haloperidol 2.5 mg oral every 12 hours for dementia with psychosis and agitation manifested by resisting care and continuous yelling out interferes with care and safety. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 51's Physician's order Report dated 10/12/2024 - 11/12/2024, the report indicated, starting 7/29/2024, monitor the resident for side effects every shift for anti-psychotic use (Seroquel and Haloperidol) - Observe closely for significant side effects: Common - sedation, drowsiness, dry mouth, constipation, blurred vision, extrapyramidal reaction, weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention. Special attention for tardive dyskinesia, seizure disorder, chronic constipation, glaucoma, diabetes, skin pigmentation, jaundice. During a review of Resident 51's physician's order dated on 9/23/2024 and timed at 9:39 p.m., the order indicated Ativan 0.5 mg, every 12 hours as needed for anxiety manifested by constantly yelling [TRUNCATED]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43906 Based on observation, interview, and record review the facility failed to ensure the controlled medications (Controlled Medications are substances that have an accepted medical use (medications which fall under US Drug Enforcement Agency (DEA) Schedules II-V), have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence) was stored and kept with double locked and was not accessible for non- nursing staff. This deficient practice has the potential to have drug diversion or drug misuse. Findings: During an initial tour on 11/8/2024 at 7:45 p.m. at the North and South Station it was observed that emergency kit with Ativan (belongs to a drug class called benzodiazepines) stored in the refrigerator with no lock. During an interview on 11/8/2024 at 7:47 a.m. with Licensed Vocational Nurse 3(LVN 3), LVN 3 stated that the refrigerator was never locked. LVN 3 stated that emergency kit was kept inside the refrigerator with Ativan inside the Emergency- kit(E-Kit) box. During an interview on 11/132024 at 2:16 p.m. with the Director of Nursing (DON), the DON stated Ativan are considered controlled medication and should have been kept double locked so no one can access the medication, it is risk to have diversion or misuse if it is not accounted properly. DON added that no one really corrected the problem until recently that caught her attention that it is a controlled medication. During a record review of the facility's policy and procedure(P &P) controlled drugs revised 12/15, the P&P indicated controlled drugs routinely administered controlled drugs may legally be stored with non-controlled medications. However, under no circumstances will a schedule II drugs be stored with non-controlled medications as these should be under double lock.

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on interview and record review the facility failed to ensure the facility's consulting pharmacist (PH) conducted monthly and as needed Drug Regiment Reviews ([DRR]thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication) of psychotropic medications (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) and made recommendations for gradual dose reduction ([GDR] - tapering mediation dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the medication can be discontinued altogether) or medication dosage adjustments to control behavioral symptoms for two of two residents with dementia (a progressive state of decline in mental abilities) for 2 of 25 sampled residents (Resident 17 and Resident 51) and for 23 residents (Residents 1, 2, 4, 9, 10, 13, 14, 19, 20, 22, 23, 26, 27, 29, 31, 32, 35, 38, 44, 45, 47, 53, 60) receiving psychotropic medications to ensure the residents were not receiving duplicate therapy (multiple medications for the one diagnosis) and unnecessary medications. The facility failed to: 1. Ensure Resident 17 had DRR and GDR assessments of psychotropic medication by the facility's PH or documentation by the physician that a dose reduction was not recommended as the benefits of the current dose outweighed the risk for side effects. Resident 17 was admitted on [DATE], and has been on the following psychotropic medications: Cymbalta (drug used to treat depression - a mood disorder that causes a persistent feeling of sadness and loss of interest) 30 milligrams ([mg] unit of weight measurement), started 11/1/2024, once a day, Ativan (drug that is used to treat anxiety [feeling of fear, dread, and uneasiness]) 0.5 mg, started 9/14/2022, twice a day for anxiety manifested by periods of restlessness or agitation that interferes with care, Seroquel, an antipsychotic (a class of drugs used to treat symptoms of psychosis [a severe mental condition in which thought, and emotions are so affected that contact is lost with reality]) 50 mg, started on 6/2/2023, every 12 hours for bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and Depakote (a medication used to treat manic episodes [emotional highs- associated with bipolar disorder]) 250 mg, started 11/2/2024, twice a day for bipolar disorder. 2. Ensure Resident 51 had a DRR and GDR assessment by the facility PH for psychotropic medication or documentation by the physician that the dose reduction was not recommended as the benefits of the current dose outweigh the risk for side effects. Resident 51 was admitted to the facility on [DATE] and has been on the following psychotropic medications: Donepezil (medication to treat dementia), oral, 5 mg once a day started on 12/19/2023. Seroquel 50 mg, oral, twice a day for dementia with agitation starting on 7/17/2024. Ativan 0.5 milligrams oral, every 12 hours as needed for anxiety manifested by constantly yelling that interfere with self and other residents. The order was started on 7/20/2024. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. Ensure staff followed the facility's policy and procedure (P&P) titled, Antipsychotic Medication Use indicating antipsychotic, a class of drugs that treat symptoms of psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), medication will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. Residents 1, 2, 4, 9, 10, 13, 14, 17, 19, 20, 22, 23, 26, 27, 29, 31, 32, 35, 38, 44, 45, 47, 51, 53, and 60 will only receive antipsychotics medications when necessary to treat specific conditions for which they are indicated and effective. These deficient practices placed Residents 17, 51 and Residents 1, 2, 4, 9, 10, 13, 14, 17, 19, 20, 22, 23, 26, 27, 29, 31, 32, 35, 38, 44, 45, 47, 51, 53, and 60 who were receiving psychotropic medication at high risk for receiving unnecessary psychotropic medication, potential side effects associated with the use of these medication, and not to have behavioral symptoms under control. Potential side effects of psychotropic medications including the following: a. Ativan: drowsiness and confusion b. Haloperidol (drug used to treat mental illness such as psychosis): difficulty speaking/swallowing, loss of balance, muscle spasms, and extrapyramidal symptoms (EPS - motor problems that include Parkinsonian-like symptoms (stiffness, tremor, shuffling gait [walking without lifting feet completely off the gound]), acute dystonia (abrupt spasms of head and neck), and akathisia (physical restlessness) c. Seroquel: increased mortality (death) in elderly patients with dementia, chills, confusion, and dizziness. d. Depakote: confusion, crying, delusions (altered reality that is persistently held despite evidence or agreement to the contrary) of persecution, mistrust, and combativeness. e. Cymbalta: body aches, cough, constipation (a common condition that involves infrequent or difficult bowel movements), and dry mouth. f. Donepezil: diarrhea, loss of appetite, and trouble sleeping On 11/14/2024, at 5:42 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation has cause, or is likely to cause, serious injury, harm impairment or death to a resident) was called in the presence of the Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to ensure the facility's consulting PH conducted monthly DRR's and GDR's monthly and as needed and made recommendations for psychotropic medications to control behavioral symptoms for 25 residents (Residents 1, 2, 4, 9, 10, 13, 14, 17, 19, 20, 22, 23, 26, 27, 29, 31, 32, 35, 38, 44, 45, 47, 51, 53, and 60) receiving psychotropic medications to ensure the residents were not receiving duplicate therapy and unnecessary medications. On 11/16/2024 at 6:48 p.m., the facility submitted an acceptable IJ removal Plan ([IJRP] - interventions to correct the immediacy of the deficient practices) and after onsite verification through observation, record review and interviews, the IJ was removed in the presence of the DON. The IJRP included the following immediate actions: (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. The facility contacted the consulting PH on 11/14/2024, to conduct a drug regimen review for Residents 17 & 51 who were on psychotropic medications for irregularities, appropriateness and make recommendations on GDR's by 11/15/2024. Additionally, the licensed pharmacist will complete psychotropic drug regimen reviews for the remaining 24 residents on psychotropic medications to assess for irregularities, appropriateness and make recommendations on GDR's by 11/15/24. 2. On 11/14/2024, all licensed nurses working on 3-11 shift were in- serviced (educated, trained) immediately on the need for a licensed pharmacist to review the resident's drug regimen and review duplicate therapy. The Director of Staff Development (DSD) will do another in service on 11/15/24 for those licensed nurses that were not at the facility on 11/14/2024. The DSD has a list of those on leave, vacation or who were not able to attend and when they are back on schedule will be in serviced as well. 3. This facility will ensure the admission of residents whose needs we can meet according to our Facility Assessment (a review of the facility's resources and capabilities to provide care for its residents) dated, 11/14/2024 through the utilization of the facility consulting pharmacist to conduct DRR for residents on psychotropic medications for irregularities, appropriate and make recommendations on GDR's. The facility's consulting pharmacist will conduct this monthly for all current and future residents. 4. The DON will monitor monthly that the consulting PH has conducted a drug regimen review for residents who are on psychotropic medications for irregularities, appropriateness and make recommendations on GDR's. The DON will report any recommendations made to the resident's physician. The DON will use the audit form to track all GDR recommendations and keep copies of the GDR recommendations in the audit binder with the audit form. The DON will monitor that 100% of the residents on psychotropic medications were reviewed by the consulting pharmacist and will report the findings to the facility's Quality Assurance Performance Improvement quarterly monitoring meetings with a threshold of 100% through November 2025. Findings: A. During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was admitted to the facility on [DATE] with diagnoses including dementia with other behavioral disturbance, bipolar disorder, generalized anxiety disorder (mental health condition that causes people to experience excessive and uncontrollable worry about everyday events or activities), major depressive disorder, abnormalities of gait and mobility. During a review of Resident 17's Minimum Data Set ([MDS] - a resident assessment tool), dated 10/3/2024, the MDS indicated Resident 17's cognition (the mental process of thinking, understanding, and processing information) was severely impaired. The MDS indicated the resident was independent when eating, needed set up assist with oral hygiene, needed moderate assist (helper does less than half the effort) with personal hygiene, needed maximal assistance (helper does more than half the effort) with showering, and was dependent on staff with toileting hygiene. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The MDS indicated Resident 17 was on antipsychotic medications since admission. Resident 17 was on the following psychotropic medications: Cymbalta 30 milligrams started 11/1/2024, once a day for depression, Ativan 0.5 mg, started 9/14/2022, twice a day for anxiety, Seroquel 50 mg, every 12 hours for bipolar disorder and Depakote 250 mg, started 11/2/2024, twice a day for bipolar disorder. The MDS also indicated a GDR had not been attempted and the physician had not documented a GDR was clinically contraindicated (a reason for a person to not receive a particular treatment or procedure because it may be harmful). During a review of Resident 17's Physician's Order Report dated 11/1/2024 - 11/10/2024, the Physician's Order Report indicated the following orders: a. Starting, 6/2/2023, Seroquel 50 mg oral, every 12 hours, for bipolar disorder, depressive type manifested by easily getting irritated or angry and suspicious at anything you say that interferes with care. b. Starting 11/1/2024, Cymbalta capsule delayed release (medication designed to release in the body over time) 30 mg, oral once a day. c. Starting 11/1/2024, Depakote delayed release tablet 250 mg, oral, twice a day, for bipolar disorder, depressive type manifested by easily getting irritated or getting angry and suspicious of anything you say, that interferes with care. During an observation of Resident 17, on 11/8/2024 at 7:18 p.m., in Resident 17's room, Resident 17 was observed falling asleep while brushing her teeth. During an observation of Resident 17 on 11/9/2024 at 9:25 a.m., in the hallway in front of Resident 17's room, Resident 17 was observed sleeping in her wheelchair. During an observation of a medication pass on 11/10/2024 at 8:51 a.m., Resident 17 stated to Licensed Vocational Nurse (LVN 3) that it was too much medication pills, LVN 3 was giving her to take. LVN 3 responded by instructing Resident 17 to drink more water and take the medication. During an interview and record review on 11/12/2024 at 9:15 a.m., with the Assistant Director of Nursing (ADON), Resident 17's Physician Progress note, dated 11/1/2024 and timed at 3:40 p.m., was reviewed. The Physician Progress note indicated Resident 17's psychotropic medications were adjusted over the last several months due to Resident 17's complaint of feeling low in energy and drooling (saliva flowing out of your mouth unintentionally). The Physician Progress note indicated that the psychotropic medications made it difficult for Resident 17 to think. The ADON stated primary physician 2 (MD 2) managed Resident 17 psychotropic medications. The ADON stated Resident 17 was diagnosed with bipolar disorder and major depression, but the last psychiatric consultation Resident 17 had was on 11/29/2021. During an observation and interview on 11/12/2024 at 2:54 p.m., with Certified Nurse Assistant (CNA) 3, by the door of Resident 17's room, Resident 17 was observed sleeping in her wheelchair. CNA 3 looked at Resident 17 and stated Resident 17 usually dozed off and fell asleep in her wheelchair, so the staff would put her back in bed. (continued on next page)

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	055539	A. Building B. Wing	11/15/2024

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

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a phone interview on 11/13/2024 at 7:49 a.m., the facility's consulting PH stated that drooling or excessive salivation can be a side effect of psychotropic medication use. The PH stated psychotropic medication use was worse for elderly and even worse for dementia residents. The PH stated inappropriate psychotropic medication use can cause residents to be drowsy or sedated (falling asleep as a side effect of a drug). During an interview and record review on 11/13/2024 at 9 a.m., with the Assistant Director of Nursing (ADON), Resident 17's Behavior Quarterly Management Follow up, dated 7/3/2024, was reviewed. The ADON confirmed and stated Resident 17 was on Ativan 0.5 mg twice a day for anxiety manifested by episodes of restlessness or agitation that interferes with care. The Behavior Quarterly Management Follow up indicated for the month of January 2024, Resident 17 had zero episodes of restlessness and one episode of agitation. For the month of February 2024, Resident 17 had 4 episodes of restlessness and 3 episodes of agitation. For the months of March and April 2024 Resident 17 had no episodes of agitation and restlessness. The ADON stated Resident 17 was on Seroquel 50 mg every 12 hours for bipolar disorder, depressive type manifested by Resident 17 gets easily irritated or gets angry and suspicious of anything you say, that interferes with care. The ADON stated during the months of January, February and March 2024 Resident 17 had behaviors of easily getting irritated and paranoia (extreme unjustified fear and mistrust of others), and in the month of April 2024 the resident had zero behaviors manifested. The ADON stated, Seroquel was last increased to every 12 hours on 6/2/2023, last year, and the Interdisciplinary Team (IDT -the residents health care team consisting of various specialties) team decided to continue the current psychotropic regimen because the benefits outweighed the risks for reduction. The ADON stated the physician was not contacted because the IDT team had decided there were no pharmacological (medication) adjustments required. The form indicated no physician's signature showing a physician or a psychiatrist was not consulted about IDT's decision not to complete a GDR. The ADON stated they don't factor in how the length of time the residents have been on psychotropics. The ADON stated the IDT only considers the behavior summary when discussing a possible GDR for the resident. B. During a review of Resident 51's Admission Record, the Admission Record indicated Resident 51 was admitted to the facility on [DATE] with diagnoses including dementia with psychotic (set of symptoms that indicate a loss of touch of reality) disturbance, and anxiety disorder. During a review of Resident 51's MDS, dated [DATE], the MDS indicated the resident's cognition was severely impaired. The MDS indicated Resident 51 was dependent on staff with bathing, toileting hygiene, dressing, personal hygiene, oral hygiene, and transfer to and from the bed to a chair. The MDS indicated Resident 51 was routinely on antipsychotic medications since admission. Resident 51 was admitted to the facility on [DATE] and has been on the following psychotropic medications: Donepezil (medication to treat dementia), oral, 5 mg once a day started on 12/19/2023. Seroquel 50 mg, oral, twice a day for dementia with agitation starting on 7/17/2024. Ativan 0.5 milligrams oral, every 12 hours as needed for anxiety manifested by constantly yelling that interfere with self and other residents starting on 7/20/2024. The MDS also indicated a GDR had not been attempted. The MDS indicated that the physician had not documented that a GDR was clinically contraindicated. During a review of Resident 51's Physician's order Report (active orders) dated 10/12/2024 - 11/12/2024, the Physician's order Report indicated the following orders: a. Starting on 12/19/2023, Donepezil (medication to treat dementia), oral, 5 mg, once a day. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	b. Starting on 7/17/2024, Seroquel 50 mg, oral, twice a day for dementia with agitation. c. Starting on 7/20/2024, Ativan 0.5 milligrams oral, every 12 hours as needed for anxiety manifested by constantly yelling that interfere with self and other residents. The order was discontinued on 9/23/2024. During a review of Resident 51's Progress Notes, the Progress Notes indicated: a. On 6/25/2024 at 11:04 a.m., Resident 51 was noted with behaviors of agitation, yelling out, and constantly moving. The Progress Note indicated that the Assistant Director of Social Services (ADSS) provided the resident with increased opportunity to socialize and engage in activities. b. On 6/29/2024 at 4:05 p.m. Resident 51's family (FM 1) reported that Resident 51 was frequently moving her lips from front to back and side to side and her eyes stayed wide open without blinking much, as the resident did in the hospital. The Progress Note indicated the MD was made aware, and Resident 51 was to be monitored for frequently moving her lips from front to back and side to side, and for her eyes staying wide open without blinking. c. On 7/11/2024 at 3:15 p.m., the Progress Notes indicated that Resident 51 displayed uncontrollable disruptive behavior, yelling out, hello for no apparent reason. The Progress Notes indicated that Resident 51's Primary Care Physician (PCP), who is not a psychiatrist ordered Seroquel 12.5 mg oral, twice a day ordered for dementia with agitation manifested by resisting care and yelling out that interferes with care and safety. d. On 7/17/2024 at 10:42 a.m., the PCP increased the dosage of Seroquel to 50 mg for dementia with agitation manifested by resisting care and yelling out that interferes with care and safety. The Progress Notes indicated that a neurologist (medical doctor who diagnoses, treats, and manages disorders of the brain and nervous system -brain, spinal cord and nerves) evaluation was pending. During a review of Resident 51's Physician's order Report (active orders) dated 10/12/2024 - 11/12/2024, the Physician's order Report indicated the following orders: a. Starting on 12/19/2023, Donepezil (medication to treat dementia), oral, 5 mg, once a day. b. Starting on 7/17/2024, Seroquel 50 mg, oral, twice a day for dementia with agitation. c. Starting on 7/20/2024, Ativan 0.5 milligrams oral, every 12 hours as needed for anxiety manifested by constantly yelling that interfere with self and other residents. The order was discontinued on 9/23/2024. During a review of Resident 51's Progress notes, the Progress Notes indicated the following: a. On 7/23/2024 at 12:46 p.m., order received for psychiatric consultation due to continuous yelling out. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	b. On 7/29/2024 at 11:12 a.m., Resident 51 continued the constant disruptive yelling for 18-20 hours a day, causing multiple other residents (unidentified) to have agitative disruptive behaviors as well. Resident 51 was yelling so much Resident 51 would not eat, or drink fluids and this distressing behavior was attributing to her continued weight loss. Resident 51 was inconsolable and not redirectable. c. On 7/29/2024 the Progress Notes indicated a new order from MD 1 for Haloperidol 2.5mg oral every 12 hours for dementia with psychosis. During a review of Resident 51's Physicians Order, created on 7/29/2024 and timed at 11:09 a.m., the order indicated Haloperidol 2.5 mg oral every 12 hours for dementia with psychosis and agitation manifested by resisting care and continuous yelling out interferes with care and safety. During a review of Resident 51's Physician's order Report dated 10/12/2024 - 11/12/2024, the report indicated, the following orders: a. Starting 7/29/2024, monitor for side effects every shift of anti-psychotic use (Seroquel and Haloperidol). b. Observe closely for significant side effects: Common - sedation, drowsiness, dry mouth, constipation, blurred vision, extrapyramidal reaction symptoms ([EPS] - motor problems that include Parkinsonian-like symptoms (stiffness, tremor, shuffling gait), acute dystonia (abrupt spasms of head and neck), and akathisia (physical restlessness)1, weight gain, edema (fluid buildup in the body), postural hypotension (feeling dizzy and weak upon standing), sweating, loss of appetite, urinary retention. c. Special attention for tardive dyskinesia, seizure disorder, chronic constipation, glaucoma, diabetes, skin pigmentation (skin color changing), jaundice (yellowing of the skin or whites of eyes by buildup of waste products). During a review of Resident 51's Progress Notes, the Progress Notes indicated on 10/2/2024 at 12:35 p.m., Resident 51 was continuously yelling out nonstop and interfering with ADLs and causing social disturbance. The Progress Notes indicated Resident 51's behavior was discussed with the IDT and MD 1, and MD 1 made an order to double the dose of the Haloperidol from 2.5 mg twice a day to 5 mg twice a day and may give one additional dose of 2.5 mg. The Progress Notes indicated that MD 1 ordered a follow up with psychiatrist's consult. During a review of Resident 51's Physician's order Report dated 10/12/2024 - 11/12/2024, the report indicated, starting on 10/2/2024, Haloperidol 5 mg every 12 hours, for dementia with psychosis and agitation manifested by resisting care and continuous yelling out that interferes with care and safety. During an interview and record review on 11/12/2024 at 2:00 p.m., with the ADON, Resident 51's Progress Notes and Physician's orders were reviewed. The ADON confirmed Resident 51 was readmitted back from the General Acute Care Hospital (GACH) without any psychotropic medications on 6/11/2024. The ADON stated on 7/29/2024 Haloperidol 2.5 mg was started due to continued behaviors. On 10/2/2024 the behaviors of yelling out continued, and Haldol was increased to 5 milligrams twice a day. The ADON stated as of 11/12/2024 Resident 51 still has not had a psychiatrist consultation. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview and record review on 11/12/2024 at 2:35 p.m., with the ADSS, the Facility Matrix (a grid-like tool used to organize and analyze data about a healthcare facility) was reviewed and the Facility Matrix indicated 25 residents (Resident 14, 60, 17, 44, 2, 10, 29, 4, 32, 35, 53, 1, 26, 27, 51, 31, 45, 19, 22, 47, 38, 20, 23, 9, and 13) were on psychotropic medications. During an interview and record review on 11/12/2024 at 2:35 p.m., with the ADSS, Resident 17, and 51's latest Monthly Behavior Summary were reviewed and the ADSS confirmed and stated she (ADSS) did the psychotropic medications behavior summary for all the residents on psychotropic medications and documented it on the respective residents' medical records. The ADSS stated the IDT team including the DON, the ADON, dietician and MDS coordinator and her(ADSS) met quarterly to analyze the residents (in general) behaviors (see if there's an increase or decrease). The ADSS stated that the IDT team would then make pharmacological intervention recommendations to the primary care physicians of the residents. The ADSS stated she does not know what is considered an unnecessary psychotropic medication is because she is not clinician. During an observation in the dining room, on 11/12/2024 at 5:55 pm, Resident 51 was yelling while eating dinner. During a phone interview on 11/13/2024 at 7:49 a.m., with the facility consulting PH stated that she does not conduct review of residents' psychotropic drug regimens. The PH stated the IDT reviews the quarterly behavior management; the PH stated she expected a physician would be in attendance in IDT meetings. The PH stated she was unsure who attended. During a concurrent interview on 11/13/2024 at 10:15 am, with the ADON, Resident 51's Behavior Quarterly Management Follow up, dated 10/16/2024 and timed at 2:09 p.m. was reviewed. The ADON confirmed and stated during July 2024, Resident 51 had 26 episodes of resisting care and 144 episodes of constant yelling out, during August 2024, Resident 51 had 15 episode of resisting care and 101 episodes of constant yelling out, and during September 2024 Resident 51 had 16 episodes of resisting care and 103 episodes of constant yelling out. The ADON stated the IDT team called MD 1 and MD 1 put Resident 51 on Haloperidol. During an interview on 11/13/2024 at 3:55 p.m., the DON stated the IDT team comprised of the DON, the ADON, Registered Dietician, ADSS, MDS Coordinator, and sometimes the Director of Rehabilitation (DOR). The DON stated the IDT team conducted residents (in general) Quarterly Behavior Management meeting on psychotropic medication use. During IDT meetings the behaviors ,medications, and interventions were discussed and summated in the document tilted Behavior Quarterly Management Follow up for each resident. The ADSS does the monthly summary of behaviors. The DON stated the IDT team will discuss whether a pharmacological adjustment would be required depending on an increase or decrease of behaviors. After the IDT discussed the behaviors the DON or the ADON reach out to the respective physicians if the IDT deemed that a GDR was indicated. The DON stated the consulting PH did not make GDR recommendations and the PH did not look at the residents' behavior record because the IDT team reviewed the behaviors and made the recommendations. During a phone interview on 11/13/2024 at 4:49 p.m., the PH stated she had been the pharmacy consultant for the facility for two years. The PH stated there were 28 residents on psychotherapeutic medications. The PH stated she did not make recommendations for GDR of psychotropic medications based on her assessment. The PH stated the IDT team managed the residents on psychotherapeutic medication and not her. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a review of the facility's P&P titled, Behavioral Assessment, Interventions and Monitoring, revised 12/2016, the P&P indicated the facility will comply with regulatory requirements related to the use of medications to manage behavioral changes. During a review of the facility's Job profile for the Pharmacist Consultant, dated 4/6/2021, the profile indicated the following essential job functions: a. Evaluates the drug regimen reviews of residents in the facility, assuring appropriate drug therapy. b. Monitors the compliance of the facility with Federal and State guidelines and notes any irregularities. c. Serves as an information source regarding medication and Federal and State pharmacy regulations. d. Acts as a liaison between the pharmacy and the facility when problems need to be resolved. e. Educates nurses about problem areas within the facility and is a in areas of staff interest. f. Attends necessary meetings of the facility, pharmacy, infection control, quality assurance, and interdisciplinary team conference. g. Reviews physician's orders and evaluates for appropriate action, dosage, potential drug interactions, administration, and stability. h. Produces written reports on findings and recommendations for each monthly visit to facilities and provides reports to the Administrator, DON, and where appropriate the medical director/physician. Reviews each resident's drug regimen at least monthly. The consultant pharmacist prescriber and IDT work together to determine whether prescribed medications are indicated based on: a. Need for the medication in relation to resident's documented diagnosis and condition. b. Whether the physician's indications for use have been documented for all medications. c. The medications effectiveness. d. Risk related to administration, including known incidence of adverse drug reactions and potential error know drug-drug and food interactions. 44055

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43906 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 21) was provided with a Physical Therapy (PT-therapy that is used to preserve, enhance, or restore movement and physical function)/ Occupational Therapy (OT-therapy that helps improve the ability to perform everyday tasks, like getting dressed, eating, or writing) evaluation as per physician order. This deficient practice resulted in delayed PT/OT evaluation and treatment for Resident 21. Findings: During a review of Resident 21's Face Sheet, the Face Sheet indicated Resident 21 was admitted to the facility on [DATE] with the diagnosis of dementia (a progressive state of decline in mental abilities). During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool) dated 10/31/2024, the MDS indicated Resident 21's cognition was moderately impaired for daily decision making and Resident 21 was dependent (helper does all of the effort and resident does none of the effort to complete the activity) on facility staff to complete activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) During a review of Resident 21's care plan dated 10/31/2024 and related to Resident 21's ADL functional status/rehabilitation (Rehab-therapy given to restore an individual back to their highest possible level of physical, mental, and psychosocial well-being) potential, the care plan indicated an intervention of rehab screening or treatment as needed. During a review of Resident 21's Rehab Screening note dated 11/13/2024, the Rehab Screening note indicated Resident 21 has moderate/severe limitation of movement in bilateral lower extremities, more in the left than right. The Rehab screening note indicated PT/ OT evaluation for contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) /orthotic (brace or splint used to support, align, prevent, or correct the function of movable parts of the body) management was recommended for Resident 21. During a review of Resident 21's Physician order dated 11/26/2024, the Physician order indicated PT/OT evaluation under Part B (medical insurance program) for contracture/orthotic management. During a review of Resident 21's insurance authorization (health plan's approval for a service or prescription) dated 12/18/2024, the insurance authorization indicated Resident 21 was approved for physical therapy with a start date of 12/10/2024. During an interview on 1/16/2025 at 3:20 p.m. with the Social Services Director (SSD), the SSD stated she send an email to the Director of Rehab (DOR) when she received a copy of the insurance authorization on 12/18/2024. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/2025 at 4:49 p.m. with the DOR, the DOR stated he missed the email regarding Resident 21's insurance authorization that was sent by the SSD on 12/18/2024. The DOR stated the PT/OT evaluation should have been completed after the insurance authorization was received on 12/18/2024. The DOR stated the purpose of the PT/OT evaluation is to maintain Resident 21's joint mobility and reduce the risk of mobility declining. The DOR stated if there is a delay with completing the PT/OT evaluation, there is a potential for Resident 21's contracture becoming worse. During a review of facility's policy and procedure (P/P) titled Resident Mobility and Range of Motion dated 7/2017, the P/P indicated residents with limited range of motion and limited mobility will receive appropriate services to increase and/or prevent further decrease in ROM and will receive appropriate services, equipment, and assistance to maintain or improve mobility unless reduction in mobility is unavoidable.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 44055 Based on interview and record review, the facility failed to provide documented evidence of 10 hours of continued education in the field of Infection Prevention and Control (IPC) for the Director of Nursing (DON), Assistant Director of Nursing ADON), and Director of Staff Development (DSD). This failure had the potential to result in negative health outcomes for the staff and residents of the facility. Findings: During an interview on 11/10/2024 at 3:23 p.m., with DON, ADON, and DSD, the DON, ADON, and DSD stated they do not have annual 10 hours of continuing education in the field of Infection Prevention and Control after the initial training was completed in 2019. During an interview and record review on 11/10/2024 at 3:23 p.m., with the ADON, the California Department of Public Health All Facilities Letter (AFL) 20-84, titled, Infection Prevention Recommendations and Incorporation into the Quality and Accountability Supplemental Payment (QASP) Program, 11/4/2020, was reviewed. The ADON confirmed that the AFL indicated it was important that each facility's Infection Preventionist has training in fundamental Infection Prevention and Control principles to effectively perform the IP duties. Ongoing education was necessary to remain aware of new information, trends, best practices, and to refresh existing knowledge. The AFL indicated The IP should complete 10 hours of continuing education in the field of IPC on an annual basis. Facilities should provide encouragement and support for IP staff to stay abreast of current news and training sources through a nationally recognized infection prevention and control association. During a review of the facility's policy and procedure (P&P) titled, Artesia Christian Home Infection Control Program, undated, the P&P indicated the facility shall establish an infection control programmed designed to provide a safe, sanitary, and comfortable environment for residents and the staff to help prevent the development and transmission of disease and infection.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43906 Based on observation, interview, and record review, the Quality Assessment Assurance ([QAA] to develop and implement appropriate plans of action to correct identified quality deficiencies)Committee and Quality Assurance Performance Improvement ([QAPI] designated to bring about constant and measurable improvement in the services provided at the facility for continual improvement of quality care) failed to identify: 1.The Licensed Pharmacist (LP) was not conducting Drug Regiment Reviews (DRR thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication) of psychotropic medications (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) monthly and as needed and made recommendations for gradual dose reduction (GDR - involves the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the medication can be discontinued altogether) or the medication dosage adjustment to control behavioral symptoms for residents with dementia. 2.Obtain a psychiatrist ' s (medical practitioner specializing in the diagnosis and treatment of mental illness) services for residents who were receiving psychotropic medication. 3.Establish and maintain an infection control program for residents who had a suspicious skin rash in the facility. These failures resulted in the residents of the facility at not receiving the appropriate care and services needed to achieve or maintain the highest practicable mental, physical, and psychosocial well-being. Findings: During a phone interview on 11/13/2024 with the Medical Director (MD1), MD1 stated that the facility staff never brought up in the meeting that they are looking for a Psychiatrist, MD1 stated he can refer a psychiatrist or NP if needed but he was not aware the facility needed one. MD1 stated residents that are under psychotropic medications should be seen by a psychiatrist to manage their medications and behaviors. During an interview on 11/14/2024 at 4:12 p.m., with the Director of Nursing (DON), and Administrator (Admin) both stated that they were not aware of the systemic failures that had caused the deficient practices. (continued on next page)

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Artesia Christian Home Inc.	11614 E. 183rd St Artesia, CA 90701

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a record review of the facility ' s undated QAPI plan, the plan indicated the purpose of the QAPI is to take a proactive approach to continually improve the way the facility cares for and engages with its residents. The facility strives to meet each resident's goals of care. The facility collaborates with psychological and neuropsychological providers to facilitate care for mental health, emotional and psychological needs. The facility utilizes only minimal medications for behavioral issues after non-pharmaceutical methods have failed. The Facility uses a systemic approach to determineif an in-depth analysis is needed to fully understand a problem, it's causes and implications of a change.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to implement its policy and procedures (P&P) titled, Scabies Identification, Treatment and Environmental Cleaning, and Infection Control Program, for five of 23 residents (Residents 5, 18, 19, 21, and 31) who had a suspicious skin rashes (the skin that has changes in texture or color and may be inflamed or irritated) by failing to: 1.Ensure Residents 5, 18, 19, 21 and 21, who had red scattered inflamed red spots with bumps and itching, were placed on isolation (separation of residents with an infection from residents without an infection). 2.Initiate and conduct infection surveillance (close observation or monitoring) by completing a line listing (a table that contains key information about each case in an outbreak) of residents with a suspicious rash in the Dementia (a progressive state of decline in mental abilities) Unit (a secure environment that provides specialized care for people with dementia). 3.Ensure precautionary measures were implemented to ensure suspicious rashes were contained for Residents, 5, 18, 19, 21, 31 and other residents in the secured unit 4.Coordinate with the local Department of Public Health to obtain guidance on how to handle the suspicious rashes. These deficient practices had the potential to spread a suspicious rash infection to all residents, staff, vendors, and visitors of the facility. On 11/10/2024 at 8:11 p.m., an Immediate Jeopardy ([IJ] a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to establish and maintain an for five residents (Resident 19, 31, 5, 18, and 21) with suspicious skin rashes. The facility had 23 total residents in the dementia unit. On 11/11/2024 the facility submitted an acceptable IJ Removal Plan ([IJRP] interventions to immediately correct the deficient practices). After onsite verification of the facility's IJRP's implementation through observation, interview, and record review, the IJ was removed on 11/11/2024 at 5:56 p.m., in the presence of the facility's DON and ADM. The facility's IJRP included the following immediate actions: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. The facility conducted body skin assessments on the five residents listed on the IJ document. Resident 19, Resident 5, Resident 18, and resident 31 had rashes. Resident 21 did not have rashes but had scratches on her skin. All five residents were placed on contact isolation (precautions intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the person or the person's environment) with no stop date as of now. Additionally, the facility conducted body skin assessments on the remaining 18 residents in the Covenant Care Unit- the dementia unit referenced in the IJ document the facility was provided (CCU), no rashes were found on the remaining 18 residents. A line list was created for all 23 CCU residents. The facility also created a CCU Line List for Skin Rashes for staff that work in CCU. The facility staff were contacted, or messages were left for those staff assigned in CCU, to inquire if they had any rashes. 25 staff were called and 16 said they have no rashes. The facility staff will follow up with the other staff in the morning on 11/11/2024. On 11/11/2024 facility staff followed up with the remaining staff and they reported no rashes. All 25 CCU staff denied having rashes. 2a. On 11/10/2024 at 8:51p.m., the facility notified the Medical Director (MD 1) of all the interventions that are being implemented. MD 1 agreed to the dermatologist consult order for Resident 21, who did not have rashes but had scratches on her skin. 2b. The facility notified the Primary Care Physician (PCP) 1 on 11/10/2024 at 9:10 p.m., of this said IJ. PCP 1 is the Physician for 3 of the residents (Residents 5, 18 and 31). PCP 1 did order dermatology consults for the 3 residents. PCP 1 also gave a new order for Hydroxyzine (medication that treats the symptoms of allergies and allergic reactions) as needed for Resident 18. 2c. PCP 2 was notified on 11/10/2024 at 9:20 p.m., of this said IJ. PCP 2 is the physician for resident 19. PCO 2 ordered a dermatology consult for Resident 19. 2d. On 11/11/2024, The Director of Social Services Department (DSSD) was able to schedule the dermatology appointments for the 5 residents (Residents 19, 5, 18, 21, 2 3) whose families agreed to dermatology consults. Two residents will go to the dermatology appointment on Tuesday 11/12/2024 (Residents 19 and 31). The other three residents will go to their dermatology appointments on Thursday 11/14/2024 (Residents 5, 18, and 21). 3. The facility also notified the CDPH (non-licensing division) on 11/10/2024 at 10 p.m. The DON spoke to county operator #10. Then operator #10 transferred DON to the on-call MD. The DON spoke to the on-call MD from 10:01 p.m. to 10:15 p.m. The DON reported the IJ and the current skin issues for said residents. The DON also reported all interventions the facility has done and implemented. The on-call MD said the case will be referred to the local regional Public Health Nursing (PHN) team and the PHN team will connect with the facility. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. On 11/10/2024 all Licensed Nurses and Certified Nursing Assistants (CNAs) working on the 3 p.m.-11 p. m. shift were in serviced immediately on skin issues, infection control, use of PPE (personal protective equipment refers to protective clothing, gloves and facemasks or other equipment designed to protect the wearers from injury or the spread of infection or illness) and isolation precautions (precautions used to reduce transmission of microorganisms in healthcare). Upon arrival today, 11/10/2024, the 11 a.m.- 7 p.m., shift licensed nurses and CNAs were also in-serviced on the same topics. The Director of Staff Development (DSD) would complete another in-service on 11/11/2024 for those staff that were not in the facility today. On Monday 11/11/2024 the DSD did an in-service again for those staff who were not at the facility yesterday (11/10/2024). The DSD has a list of those on leave, vacation or who were not able to attend and when they are back on schedule will set a date for an in-service as well. The facility also implemented the precautionary measures listed in paragraph 1, 2 and 3. 5. The facilities Infection Preventionist (IP) or designee would monitor and track any residents with suspicious rashes and maintain an infection control program by ensuring they are added to line listings for surveillance purposes, placed on isolation, ensure precautionary measures were done and implemented and reach out to DPH when facility staff suspect an outbreak has occurred for additional guidance on how to handle the situation. A root cause analysis would be done for those residents with suspicious rashes. The facilities IP or designee would report the findings to the facilities quarterly QAPI (Quality Assurance and Performance Improvement- a data driven proactive approach to improvement used to ensure services are meeting quality standards) monitoring meeting with a threshold of 100% compliance through November 2025 for all current and future residents have the potential to be affected by this deficient practice. Findings: 1a. During a review of Resident 5's Admission Record (AR), the AR indicated Resident 5 was admitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities). During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool) dated 10/3/2024, the MDS indicated Resident 5's cognition (ability to process and understand information) was severely impaired. The MDS indicated Resident 5 was dependent (helper does all the effort) on facility staff to complete activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 5's Progress Notes dated 10/25/2024, the Progress Notes indicated Resident 5's physician was notified regarding Resident 5's generalized rashes which appeared like red lesions (an area of abnormal or damaged tissue caused by injury, infection, or disease) with bumps, dry and rough in texture, and occasionally itching by Resident 5. The Progress Note indicated Resident 5's physician ordered permethrin cream (medication used to treat scabies, a condition caused by tiny insects called mites that infest and irritate the skin) 5% to treat the rashes. During a review of Resident 5's Physician Order (PO), dated 10/25/2024, the PO indicated permethrin 5% to be applied to Resident 5's body from the neck to sole of the feet overnight for 8 hours and wash off in the morning for generalized rashes once a day on Friday for 2 weeks. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 5's Treatment Administration Record (TAR) for 10/2024 and 11/2024, the TAR indicated permethrin cream 5% was administered/applied to Resident 5 on 10/25/2024 and 11/1/2024. 1b. During a review of Resident 18's AR, the AR indicated Resident 18 was admitted on [DATE] with hospice care (a comprehensive, holistic program of care and support for terminally ill patients and their families) and diagnoses including dementia. During a review of Resident 18's MDS, dated [DATE], the MDS indicated Resident 18's cognition was severely impaired. The MDS indicated Resident 18 was dependent on facility staff to complete ADLs. During a review of Resident 18's POs, dated from 10/24/2024 to 11/7/2024, the POs indicated: On 10/24/2024, an order for scattered rashes on upper back: cleanse with soap and water, pat dry and apply hydrocortisone cream (cream to reduce swelling, itchiness, and redness in skin conditions) 1 percent (%), twice a day for 14 days. On 11/7/2024, an order for scattered rashes on the chest: cleanse with soap and water, pat dry and apply hydrocortisone cream 1%, twice a day for 14 days. On 11/7/2024, an order for scattered rashes on upper back: cleanse with soap and water, pat dry and apply hydrocortisone cream 1%, twice a day for 14 days. During a review of Resident 18's Progress Notes (PN), dated 10/24/2024, the PN indicated Resident 18 was experiencing scattered rashes on the chest and upper back which appeared to be red spots with bumps and appeared inflamed (red, sore, and often swollen). The PN indicated PCP 1 ordered hydrocortisone cream 1%, twice a day for a duration of 14 days. During a review of Resident 18's PN, dated 11/7/2024, the PN indicated a new order was received from the Hospice Nurse (HN) to continue to cleanse the rashes on the upper back and chest with soap and water, pat dry and apply hydrocortisone cream 1% for a duration of 14 days. During a review of Resident 18's untitled Care Plan (CP), dated 10/24/2024 related to Resident 18's rashes on the chest and upper back, the CP indicated a goal for the rashes to heal without complication. The CP interventions indicated treating the rashes per physician's order. During a review of Resident 18's Medication Administration Records (MARs) dated 10/2024 and 11/2024, the MARs indicated that 10/24/2024 -11/10/2024, Resident 18 received hydrocortisone cream 1% to the scattered rashes on the chest and upper back. 1c. During a review of Resident 19's AR, the AR indicated the facility admitted Resident 19 on 10/16/2023 with diagnoses including dementia. During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19's cognition was severely impaired. The MDS indicated Resident 19 was dependent on facility staff to complete ADLs. During a review of Resident 19's POs, dated 10/12/2024, the POs indicated: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An order for a dermatology consult for generalized rashes. An order for Permethrin cream 5 % apply to whole body with special instructions to apply from the neck down to sole of the feet overnight for 8 hours and wash off in morning for generalized rashes, once a week on Tuesday for 2 weeks. During a review of Resident 19's PN, dated 10/22/2024 at 4:19 p.m., the PN indicated an order from PCP 1 to obtain a dermatologist consult when available for generalized rashes. During a review of Resident 19's PN, dated 10/22/2024 at 4:55 p.m., the PN indicated PCP 1 was contacted to inform PCP 1 of Resident 19's rashes starting in the mid chest, spreading to the left upper arm, posterior back, right upper chest, left hip, and right posterior thigh. The PN indicated the rashes appeared as small, scattered scabs (the crusty patch of skin that forms when a scrape or cut is healing) with reddened surrounding areas. The PN indicated Resident 19 was reporting occasional itching, and PCP 1 ordered Permethrin cream 5%. During a review of Resident 19's untitled CP, dated 10/4/2024, the CP indicated Resident 19 experienced rashes on the mid chest and left upper arm. The CP indicated a goal for Resident 19's rashes to heal without complication with the interventions of discouraging resident from scratching and treating the rashes per physician's order. During a review of Resident 19's MAR for 10/2024, the MAR indicated Resident 19 received a dose of Permethrin cream 5%, applied to the whole body on 10/22/2024. 1e. During a review of Resident 21's AR, the AR indicated Resident 21 was admitted on [DATE] with diagnoses including dementia. During a review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 21's cognition was moderately impaired. The MDS indicated Resident 21 was dependent on facility staff to complete ADLs. During a review of Resident 21's PO, dated 11/6/2024, the PO indicated for the scattered rashes on the chest: cleanse with soap and water, pat dry and apply a thin layer of hydrocortisone cream 1% and leave open to air twice a day for a duration of 14 days. During a review of Resident 21's Skin Integrity Events- Rash/Lesions document, dated 11/6/2024, the Skin Integrity Events- Rash/Lesions document indicated Resident 21 had scattered redness on the chest. During a review of Resident 21's TAR for 11/2024, the TAR indicated from 11/6/2024 through 11/9/2024, Resident 21 had scattered rashes to the chest which were cleansed with soap and water, patted dry and a thin layer of hydrocortisone cream 1% was applied. 1f. During a review of Resident 31's AR, the AR indicated Resident 31 was admitted on [DATE] with diagnoses including dementia. During a review of Resident 31's MDS dated [DATE], the MDS indicated Resident 31's cognition was severely impaired. The MDS indicated Resident 31 was dependent on facility staff to complete ADLs. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 31's PO, dated 10/1/2024, the PO indicated an order for the scattered rashes on abdomen: cleanse with soap and water, pat dry, and apply Hydrocortisone cream 1 %, twice a day for a duration of 14 days. During a review of Resident 31's PN, dated 11/8/2024, the PN indicated Resident 31 was experiencing rashes that spread throughout the chest and hip. The PN indicated the rashes appeared pink and raised, and mild itchiness was observed. The PN indicated PCP 1 was notified and PCP 1 ordered to continue the current treatment of hydrocortisone cream. During a review of Resident 31's PN, dated 11/8/2024, the PO indicated an order for generalized rashes: cleanse with soap and water, pat dry, and apply Hydrocortisone cream 1% twice a day for a duration of 14 days. During a review of Resident 31's untitled CP, dated 11/1/2024, the CP indicated Resident 31 experienced scattered rashes on Resident 31's abdomen. The CP indicated a goal for the scattered rashes healing without complication. The CP interventions included a dermatology consult. During a review of Resident 31's TAR for 11/2024, the TAR indicated Resident 31 received hydrocortisone cream 1% twice a day for scattered rashes on the abdomen from 11/1/2024 -11/10/2024. During a review of the facility's Housekeeping Checklist for 11/2024, the SNF Housekeeping Checklist indicated privacy curtains were changed every quarter (January, April, July, and October) beds, closets, lamps, and furniture are cleaned every month. During an interview on 11/9/2024 at 1:05 p.m., with the Housekeeper (HK), the HK stated she has not performed any deep cleaning (a thorough cleaning that eliminates visible dirt, bacteria, and germs; is a lot more extensive than standard weekly cleaning) of any room recently in the dementia care unit. During an interview on 11/10/2024 at 6:32 a.m., with Treatment nurse (TN 1), TN 1 stated that Resident 18 was scratching and has rashes. TN 1 stated Resident 18's rash has not improved while being treated by hydrocortisone cream for 14 days starting on 10/25/2024 so the PCP 1re-ordered the hydrocortisone for another 14 days starting on 11/7/2024. During an interview on 11/10/2024 at 6:41 a.m., with Certified Nursing Assistant 1 (CNA1) regarding the rashes on Residents 18, 19 and 21, CNA 1 stated Resident 18 has a rash around Resident 18's neck, Resident 19 scratches around Resident 19's upper chest and has rashes, and Resident 21 scratches on Resident 21's upper chest and has rashes. During an interview on 11/10/2024 at 6:59 a.m., with Licensed Vocational Nurse 1 (LVN 1) regarding Resident 5, 18, 19 and 21's rashes, LVN 1 stated she has seen Resident 18 scratching Resident 18's neck; Resident 5 has a generalized rashes on Resident 19's body, Resident 19 has redness and rashes on her chest and is scratching around her upper chest; and Resident 21 has redness and scratches on Resident 21'schest area. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/10/2024 at 9:15 a.m., and 3:32 p.m., with the Assistant Director of Nursing (ADON), the ADON stated Residents 5 and 9 were ordered permethrin cream to treat rashes prophylactically (to prevent or protect against disease or infection). The DON stated there was no skin scraping (a common procedure used to obtain the superficial dead layers of the skin used to diagnose skin infections) ordered. The DON stated the residents (Resident 5 and 9) were placed in isolation when the cream was applied (duration of 8 hours), and the residents' clothing was sent to the laundry. The ADON stated no precautionary measures, to prevent the spread of the rashes were done for the roommates of Resident 5 and 19. The ADON stated there were a total of five residents who are experiencing rashes. The ADON stated there was no line listing for skin surveillance after Residents 5 and 19 were treated with permethrin cream for other residents and staff. The ADON stated in the past, the facility had experienced residents with suspicious rashes, then they administered the permethrin cream, deep cleaned the rooms, provided precautionary measures such as contact isolation for the residents, and did skin surveillance for other residents and staff at risk. During an interview on 11/10/2024 at 6:33 p.m., with the DON, the DON stated she was aware Residents 5 and 9 were treated with permethrin for generalized rashes. The DON stated Residents 5 and 9 were treated with permethrin as an off label use (used for a disease or medical condition that the medication is not approved to treat) for generalized rashes. The DON stated Resident 5 had not been assessed by dermatology for the rashes. The DON stated Resident 9 was awaiting authorization for a dermatology consult. The DON stated she was aware other residents (Residents 31, 18 and 21) were experiencing rashes, but she was unsure if a line listing for skin surveillance for residents and staff was completed. The DON stated the suspicious rashes was not reported to the Department of Public Health. The DON stated the housekeeping staff have their daily, weekly, monthly, and quarterly cleaning routines and have not completed a deep clean in the secured unit to prevent the rashes from spreading. During an interview on 11/13/2024 at 7:49 a.m., with the Facility Pharmacy Consultant (PC), the PC stated permethrin can be prescribed for prophylaxis but there is no indication it can be used off-label to treat generalized rashes. During a review of the facility's P&P) titled, Scabies Identification, Treatment and Environmental Cleaning, dated 8/2016, the P&P indicated when scabies is treated with Permethrin cream, the resident should be placed on contact precautions during treatment period and 24 hours after application of permethrin cream. The P&P indicated the resident's bed linens, towels, and clothing used during the four days prior to initiation of treatment should be placed in plastic bags inside the resident's room, handled by gloved and gowned staff without sorting, and washed in hot water for 10-20 minutes. During a review of the facility undated P&P titled, Infection Control Program, the P&P indicated the facility residents would be provided screening for infectious diseases, physical exams and health histories, infection monitoring and treatment for infectious disease. The P&P indicated surveillance (close observation) of residents would include maintenance of an infectious disease log and reporting individual incidents of infection documented in the log.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview, and record review, the facility failed to implement its protocol for antibiotic stewardship program (coordinated program that promotes the appropriate use of antibiotics at the right dose, for the right duration, and only when needed by clinicians) by not monitoring and addressing triple antibiotic (a substance used to kill bacteria and to treat infection) ointment use for two of two sampled residents (Resident 1 and 60). This failure had the potential for the Resident 1 and 60 to receive an inappropriate antibiotic. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] with diagnoses including Chronic respiratory failure (inadequate gas exchange in the body), generalized muscle weakness. The Admission Record indicated Resident 1 had a gastrotomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 10/13/2024, the MDS indicated Resident 1's cognition (ability to make decisions of daily living) was intact. The MDS indicated Resident 1 needed set up assistance with oral hygiene, moderate assistance (helper does less than half the effort) with personal hygiene, and was dependent on staff with showering, dressing and toileting hygiene. During a review of Resident 1's Physician Order Report dated 10/12/2024 to 11/12/2024, the report indicated: a. Starting 11/4/2024 to 11/18/2024, right forearm skin tear (traumatic wounds caused by friction when the upper layer of the skin becomes torn from the underlying layers) cleanse with normal saline (salt and water solution) pat dry apply triple antibiotic ointment cover with dry dressing every day for 14 days. b. Starting 11/10/2024 to 11/23/2024, left wrist skin tear cleanse with normal saline pat dry apply thin layer of triple antibiotic cover with dry dressing everyday times 14 days. During a review of Resident 60's Admission Record, the Admission Record indicated Resident 60 was originally admitted to the facility on [DATE] with diagnoses including acute respiratory failure and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 60's MDS, dated [DATE], the MDS indicated Resident 60's cognition was intact. The MDS indicated Resident 60 needed set up assistance with eating, oral hygiene, and personal hygiene, maximal assistance (helper more than half the effort) with upper body dressing and was dependent on staff with showering and toileting hygiene. (continued on next page)

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	11/15/2024

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

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 60's Physician Order Report dated 10/12/2024 to 11/12/2024, the report indicated, starting 11/9/2024 to 11/30/2024, left lower shin (front of leg below the knee) abrasion (scrape to the skin), cleanse with normal saline, pat dry apply triple antibiotic ointment daily cover with dry dressing for 7 days. During an interview on 11/11/2024 at 3:05 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the facility did not do antibiotic stewardship with triple antibiotics used for skin breaks and the facility did not monitor triple antibiotic use for residents. During an interview on 11/13/2024 at 1:12 p.m., with the Director of Nursing (DON), the DON stated triple antibiotic was an antibiotic. During a review of the facility's policy and procedure (P&P) titled, Infection Control Program, undated, the P&P indicated surveillance of residents will include Maintenance of an infectious disease log by staff, Reporting individual incidents of infection in the log, monthly record of incidents by infection sites; and auditing medical records of diagnostic tests, labs, x-ray reports and screening exams. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship Policy, undated, the P&P indicated: a. The facility will provide and ensure coordinated efforts to promote appropriate prescribing of antimicrobials and to commit to using antimicrobials only when necessary to treat, control, and prevent disease, to ensure that the correct antimicrobial is selected, and to administer all antimicrobials correctly. b. Data will be collected and summarized on a quarterly basis. Data will be reviewed by members of the Quality Assurance Committee quarterly and results and actions taken to ensure compliance to the Antibiotic Stewardship Program. c. The Infection Control Supervisor reports on the number of antibiotics prescribed and the number of residents treated each month to the Quarterly Quality Assurance Committee Meeting, including a separate report on the number of residents on antibiotics that did not meet the criteria for active infection. d. All facility Charge Nurses are responsible for completing the individual infection report using the McGreer's Criteria (see synopsis of McGreer's definition of infection) for assessment and treatment of infections. Charge Nurses are responsible for reviewing the facility antibiogram report with the treating physician to facility decision ma king by the MD based on the facilities' most current antibiogram.

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 44055 Based on interview and record review, the facility failed to provide documented evidence of all employees screening, education offering, and current Corona virus (COVID-19 a highly contagious infectious disease) disease, vaccination (medications used to prevent diseases usually given by injection or by mouth) status. This failure had the potential to place staff and residents at risk for negative outcomes such as being hospitalized and dying due to COVID-19. Findings: During an interview and record review on 11/11/2024 at 9:14 a.m., with the Assistant Director of Nursing (ADON), the facility's employee records of COVID-19 status was reviewed, and 128 facility staff COVID-19 immunization status was unknown. During an interview and record review on 11/11/2024 at 9:14 a.m., with the ADON, the County of Los Angeles Department of Public Health order of the Health Officer, Annual Influenza and Covid-19 immunization or Masking Requirement for Healthcare Personnel during Respiratory Virus Season, issued 8/26/2024, was reviewed and the order indicated by November 1 of each respiratory virus season. Healthcare provider who declined either or both an influenza or COVID-19 vaccination as described above must provide their employer, on a form provided by their employer, a written declaration for each vaccine that they have declined. The ADON stated most of the staff have not replied whether they accept or decline vaccinations. During an interview on 11/13/2024 at 1:12 p.m. with the Director of Nursing (DON), the DON stated the facility needs employees' Covid Vaccination status updated. During a review of the facility's policy and procedure (P&P) titled, Infection Control Plan, undated, the P&P indicated the objective of the Infection Control Plan to initiate ongoing employee health programs for the prevention of cross infections, including immunizations.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 43906 During an interview with the Maintenance Supervisor(MS) on 11/09/2024 at 1043 AM, the MS stated the residents in the affected rooms were not negatively impacted. The MS stated there is sufficient room for the provision of nursing services for these group of residents. the rooms were approved during OSHPD inspection. During a review of the letter provided by the DON dated 11/09/2024 , the DON requested a room waiver for the residents' room sizes less than 80 sq ft per resident for six of 18 rooms. The following resident rooms measured as followed: Room Number of beds Square Footage 34 4 305.5 35 4 305.5 36 2 151 37 2 152 38 2 152 39 2 151 During observations in these rooms throughout the survey period 11/8/2024 through 11/14/2024, there were no issues observed with the residents having access in and out of the rooms, the space for their furniture, and no problems with staff being able to administer or assist with care.