STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555565	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Artesia Palms Care Center	11900 E. Artesia Blvd. Artesia, CA 90701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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** 44958 Based on interview and record review, the facility failed to ensure a resident who had poor safety awareness with a history of an unwitnessed fall from a wheelchair on 1/2/2024, and who required staff supervision with transfers from bed to a wheelchair, did not fall during unassisted and an unsupervised transfers from bed to a wheelchair sustained an injury for one of three sampled residents (Resident 1). The facility failed to: 1. Revise Resident 1's care plan after Resident 1's fall on 1/2/2024 and develop comprehensive person-centered interventions to address Resident 1's poor safety awareness and Resident 1's noncompliance when asking for assistance prior to getting out of bed. 2. Ensure staff did not leave a wheelchair within Resident 1's reach next to the resident's bed, enabling Resident 1 not to call for assistance prior to getting out of bed and transfer unassisted to a wheelchair, causing her falls on 1/2/2024 and 6/2/2024. 3. Ensure staff followed the facility's policy and procedure (P/P) titled Fall and Fall Risk, Managing, which indicated that based on previous evaluations and current data, the staff will identify interventions related to Resident 1's specific risks and causes to try to prevent Resident 1 from falling and to minimize complications from falling. These deficient practices resulted in Resident 1 sustaining a fracture (break in bone) of the left tibia (shin) on 6/2/2024 due to an unsupervised transfer from her bed into a wheelchair on 6/2/2024. Resident 1 was transferred to a General Acute Care Hospital (GACH) on 6/2/2024 for evaluation and treatment of a displaced (gap developed between break in bones) comminuted (bone broken into three of more pieces) oblique (broken at an angle) fracture of left tibia, pain, and decreased mobility. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including generalized muscle weakness, difficulty walking, and schizophrenia (a serious mental illness that affects a person's thoughts, feelings, and behaviors). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set ([MDS]) a standardized assessment and care screening tool), dated 3/14/2024, the MDS indicated Resident 1's cognitive skills (thinking process) for daily decision-making were moderately impaired and the resident was able to understand others and was understood by others. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs) with transfers between surfaces, including from bed to a chair and from chair to bed. During a review of Resident 1's Fall Risk Observation/assessment dated [DATE], the Fall Risk Observation/Assessment indicated Resident 1's fall risk score was 18. A score of 16 and above indicated a high risk for falls. During a review of Resident 1's Change of Condition (COC) dated 1/2/2024, the COC indicated on 1/2/2024 at approximately 10 a.m., Resident 1 was found on the floor by a Certified Nursing Assistant (CNA X). During a review of Resident 1's Care Plan, dated 1/2/2024, the Care Plan indicated Resident 1 had an unwitnessed fall (1/2/2024) and was at risk for falls. The Care Plan's goals indicated, to the extent possible, minimize the risk for additional falls and Resident 1 would be compliant with fall interventions to reduce the risk of additional falls. During a review of Resident 1's Fall Risk Observation/Assessment, dated 3/14/2024, the Fall Risk Observation/Assessment indicated Resident 1's fall risk score was 22, indicating a high risk for falls. During a review of Resident 1's Physical Therapy ([PT] treatment used to restore functional movement, such as standing, walking) Discharge Summary, dated 3/8/2024, the PT Discharge Summary indicated Resident 1's functional status for transfers and for gait (the way a person walks) on level surfaces was contact guard assist (care giver places one or two hands on resident's body to help with balance). During a review of Resident 1's COC note, dated 6/2/2024, the COC note indicated on 6/2/2024 at approximately 4:45 a.m., Resident 1 was found on the floor in her room next to her wheelchair by CNA 1. The COC note indicated Resident 1 complained of pain to her left lower leg rated 10 out of 10 on a pain scale from zero to 10 (0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain). During a review of Resident 1's Nurse's Notes, dated 6/2/2024, the Nurse's Notes indicated at 4:45 a.m., a noise was noted coming from Resident 1's room. Resident 1 was found on the floor in her room close to her wheelchair. The Nurse's Notes indicated at 5:30 a.m., 911 was called due to Resident 1's uncontrolled pain to her left lower leg, Resident 1 was transferred to a GACH for further evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's Unusual Incident/Injury report, dated 6/3/2024, the Unusual Incident/Injury report indicated on 6/2/2024 Resident 1 was found lying on the floor on her left side. The Unusual Incident/Injury report indicated Resident 1 reported she was sitting in her wheelchair and was trying to shift her weight because she was not sitting in her wheelchair properly. Resident 1 reported she tried to get up from her wheelchair, but her legs got stuck/twisted and she fell . The Unusual Incident/Injury report indicated Resident 1 was transferred to a GACH (6/2/2024) for further evaluation and on 6/3/2024, the GACH reported Resident 1 sustained a fracture of the left tibia. During a review of Resident 1's Face Sheet, from the GACH, the Face Sheet indicated Resident 1 was admitted to the GACH on 6/2/2024. During a review of Resident 1's History and Physical (H/P), from the GACH, dated 6/2/2024, the H/P indicated Resident 1's Xray result showed Resident 1 sustained a left tibial fracture and she was placed in a long leg splint (an external device used to immobilize an injury or body part). During a review of Resident 1's Imaging report (Xray), from the GACH, dated 6/5/2024, the Xray report indicated Resident 1 sustained a displaced comminuted oblique fracture of the mid to distal third of the left tibia. During an interview on 6/5/2024 at 10:30 p.m., Resident 1 stated a few days ago (6/2/2024), she got out of bed and transferred to her wheelchair. Resident 1 stated she was not steady in her wheelchair and fell from it. Resident 1 stated she was able to get into her wheelchair because her bed was high enough and her wheelchair was at her bedside. Resident 1 stated she does not usually ask for assistance to get out of bed to her wheelchair because she was able to transfer independently, and the nursing staff leaves her wheelchair next to her bedside so she can reach it easily. Resident 1 stated she felt frustrated and uncomfortable because she was in pain and could not get out of bed because of her broken leg. During an interview on 6/6/2024 at 3 p.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 was a high fall risk and should be supervised during transfers from her bed to her wheelchair, but she was noncompliant and did not ask for assistance when transferring. LVN 1 stated, nursing staff often places Resident 1's wheelchair next to her bed within the resident's reach. LVN 1 stated, Resident 1 had poor safety awareness and judgement and placing her wheelchair within reach of her could increase the likelihood that Resident 1 would not call for assistance prior to getting out of bed, causing an increased risk of falls. During an interview on 6/6/2024 at 3:15 p.m., the Director of Rehabilitation (DOR) stated Resident 1 required supervision when transferring out of bed into a chair or wheelchair and back into bed. The DOR stated Resident 1 was a high fall risk and could be unsteady when transferring or ambulating without supervision The DOR stated, the IDT had not revised Resident 1's comprehensive care plans after her fall on 1/2/2024 and prior to her fall on 6/2/2024 to address Resident 1's noncompliance when asking for assistance prior to getting out of bed. The DOR stated, the IDT should have discussed specific interventions to promote safety and prevent future falls. The DOR stated she was not aware the nursing staff was placing Resident 1's wheelchair at her bedside unattended and because Resident 1 had poor judgment and safety awareness, the wheelchair could be considered an environmental hazard and increase Resident 1's risk of falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/6/2024 at 4 p.m., the Director of Nursing (DON) stated nursing staff should have ensured Resident 1's care plan interventions (resident needs were anticipated, and the resident was supervised during transfers) were implemented and revised as needed to ensure proper care and services were provided to prevent Resident 1 from falling. The DON stated he was not aware Resident 1's wheelchair was left unattended at the resident's bedside. The DON stated placing the wheelchair next to Resident 1's bed enabled the resident to transfer into the wheelchair unsupervised. The DON stated it was important for staff to supervise Resident 1 during transfers to ensure her safety. During a review of the facility's P/P titled Fall and Fall Risk, Managing, revised 1/2001, the P/P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The P/P indicated the staff with the input of the attending physician will implement resident centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. The P/P indicated if the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. During a review of the facility's P/P titled Safety and Supervision of Residents, revised 7/2017, the P/P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P/P indicated an individualized, resident centered approach to safety, the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.