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	12/19/2024

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on interview, and record review, the facility failed to ensure pain medication prescribed to one of eight sampled residents (Resident 5) had a specified indication for use on Resident 1's physician's order, the reason pain medication was administered was specified on Resident 1's medication administration record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) and the effectiveness of the pain medication was documented These deficient practices resulted in the inability to determine what the pain medication was ordered for, the location of Resident 1's pain, and/or the effectiveness of the pain medication administration. These deficient practices had the potential for non-continuity of care, unnecessary medication administration, ineffective pain relief, adverse side effects of the pain medication, and unrecognized/assessed diagnoses. Findings: During a review of Resident 5's Admission Record (Face Sheet), the Face Sheet indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including osteomyelitis (inflammation of bone or bone marrow, usually due to infection), and 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 11/22/2024, the MDS indicated Resident 5's cognition (ability to think and reason) was moderately impaired. The MDS indicated Resident 5 required moderate assistance (helper does less than half the effort) for toileting, hygiene, showering/bathing, dressing the lower body, and repositioning in bed. During a review of Resident 5's Physician's Order dated 8/20/2024, the Physician's order indicated to give two acetaminophen (a pain medication) 325 milligram ([mg] metric unit of measurement, used for medication dosage and/or amount) tablets (650 mg total) every four hours as needed for pain management. During a review of Resident 5's Physician's Order dated 9/17/2024. The Physician's order indicated to give one tablet of Ibuprofen (a pain mediation) 400 mg every six hours as needed for mild to moderate pain. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 5's MAR dated 10/13/2024, the MAR indicated Resident 5 received acetaminophen 650 mg for a pain level of 2 out of 10 (an 11 eleven point scale where pain is rated 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) at 5:35 p.m. Continued review of Resident 5's MAR indicated, the location of Resident 5's pain or relief of his pain was not identified or documented. During a review of Resident 5's MAR dated 10/13/2024, the MAR indicated Resident 5 received Ibuprofen 400 mg for a pain level of 6 out of 10 at 5:14 p.m. Continued review of Resident 5's MAR indicated, the location of Resident 5's pain or relief of his pain was not identified or documented. During a concurrent interview and record review on 12/17/2024 at 3:21 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 5's Nurse Notes were reviewed. The Nurse Notes dated 10/13/2024, indicated Resident 5 had a pain level of 6 out of 10 but there was no indication where Resident 1's pain was located. LVN 1 stated he did not remember where Resident 1's pain was located and stated he should have documented the location of Resident 1's pain and the effectiveness of the pain medication so anyone looking at Resident 1's medical record would know what happened. During an interview on 12/18/2024 at 9:30 a.m., and a subsequent interview on 12/19/2024, at 8:49 a.m., the Director of Nursing (DON) stated he was not certain why Ibuprofen was administered to Resident 5 on 10/13/2024 because Resident 5's medical record did not indicate where his pain was located or what it was ordered for. The DON stated LVN 1, who administered the Ibuprofen, should have documented where Resident 5's pain was located. The DON stated he was not aware pain medication orders needed to specify what kind of pain the pain medication was needed for, he thought orders indicating mild, moderate, or severe pain was sufficient. The DON acknowledged how not specifying the type and location of pain for administration of pain medication in the physician's order could be an issue when following up for effectiveness of treatment. During a review of the (P&P) titled Pain Assessment and Management dated 2001, the P&P indicated: The purpose of the procedure are to help staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. The P&P indicated general guidelines included recognizing the presence of pain, identifying the characteristics of pain, and monitoring for effectiveness of interventions. During a review of the facility's Policy and Procedure (P&P), titled, Medication Therapy dated 2001, the P&P indicated as part of medication regiment review, there should be a clear indication for treating individuals with medication. See F842

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on interview and record review, the facility failed to accurately document medication administration in the medical record for one out of eight residents (Resident 5). This deficient practice resulted in inaccurate documentation of the care provided to Resident 5 after he sustained a fall with injury on 10/14/2024. This deficient practice had the potential for non-continuity of Resident 5's care by other health care providers. Findings: During a review of Resident 5's Admission Record (Face Sheet), the Face Sheet indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including osteomyelitis (inflammation of bone or bone marrow, usually due to infection), and 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 11/22/2024, the MDS indicated Resident 5's cognition (ability to think and reason) was moderately impaired. The MDS indicated Resident 5 required moderate assistance (helper does less than half the effort) for toileting, hygiene, showering/bathing, dressing the lower body, and repositioning in bed. During a review of Resident 5's Physician's Order dated 8/20/2024, the Physician's order indicated to give two acetaminophen (a pain medication) 325 milligram ([mg] metric unit of measurement, used for medication dosage and/or amount) tablets (650 mg total) every four hours as needed for pain management. During a review of Resident 5's Physician's Order dated 9/17/2024. The Physician's order indicated to give one tablet of Ibuprofen (a pain mediation) 400 mg every six hours as needed for mild to moderate pain. During a review of Resident 5's MAR dated 10/13/2024, the MAR indicated Resident 5 received acetaminophen 650 mg for a pain level of 2 out of 10 (an 11 eleven point scale where pain is rated 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) at 5:35 p.m. Continued review of Resident 5's MAR indicated, the location of Resident 5's pain or relief of his pain was not identified or documented. During a review of Resident 5's MAR dated 10/13/2024, the MAR indicated Resident 5 received Ibuprofen 400 mg for a pain level of 6 out of 10 at 5:14 p.m. Continued review of Resident 5's MAR indicated, the location of Resident 5's pain or relief of his pain was not identified or documented. During a review of Resident 5's MAR Audit Tool (a tool used to determine the exact time medication administration was documented as given), the MAR Audit Tool indicated acetaminophen 325 mg tablets (650 mg total) was administered to Resident 5 at 10:10 p.m., on 10/13/2924. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 5's Nurse Note dated 10/13/2024 at 5:33 p.m., the Nurse Note indicated Resident 5 was heard yelling for help and was found on the right side of his body facing the floor. The Nurse Note indicated a full body assessment was done, Resident 1 had no injuries, and his skin was intact. The Nurse Note indicated Licensed Vocational Nurse (LVN) 1 administered Tylenol (acetaminophen) 650 mg to Resident 5 for right side head pain at 5:35 p.m. During a review of Resident 5's Interdisciplinary Team Care Conference Note ([IDT] a group of medical professionals from different disciplines who work together to help a resident achieve their goals) dated 10/14/2024, the IDT note indicated Resident 5 fell on [DATE] at 5:30 p.m., and sustained abrasions (a superficial wearing off of the skin, usually by a scrape or brush burn) on both of his knees. During a concurrent interview and record review on 12/17/2024 at 3:21 p.m., with LVN 1, Resident 5's Nurse Notes were reviewed. The Nurse Notes dated 10/13/2024, indicated Resident 5 had a pain level of 6 out of 10 but did not indicate where Resident 1's pain was located. LVN 1 stated he did not remember where Resident 1's pain was located and stated he should have documented the location of Resident 1's pain and the effectiveness of the pain medication so anyone looking at Resident 1's medical record would know what happened. LVN 1 stated he believed he gave the medication to Resident 5 at approximately 5:30 p.m., but actually documented in Resident 5's record later in the evening (10:10 p.m.) because he was busy. During an interview on 12/18/2024 at 9:30 a.m., the Director of Nursing (DON) stated in addition to documenting the resident's pain level a pain assessment should include the location, type, and onset of the resident's pain, as well as what makes the resident's pain better or worse. The DON stated assessing a resident's pain level was important in order to evaluate the effectiveness of the resident's pain management, and to see if the resident was getting better or worse. the DON stated he was not certain why Ibuprofen was administered to Resident 5 on 10/13/2024 because Resident 5's medical record did not indicate where his pain was located or what it was ordered for. The DON stated LVN 1, who administered the Ibuprofen, should have documented where Resident 5's pain was located. The DON stated Resident 5 sustained knee abrasions from his fall on 10/13/2024 and LVN 1 should not have documented Resident 5 had no injuries. The DON stated a head to toe assessment should be conducted and documented after a resident sustains a fall or has a change of condition (COC), so the resident's physician will have the correct information when deciding a course of action. During a review of the facility's P&P titled Charting and Documentation dated 2001, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The P&P indicated the following information is to be documented in the resident medical record, objective observations, medications administered. The P&P indicated documentation of procedures and treatments will include the date and time the procedure/treatment was provided, and how the resident tolerated the procedure/treatment. During a review of the (P&P) titled Pain Assessment and Management dated 2001, the P&P indicated: The purpose of the procedure are to help staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. The P&P indicated general guidelines included recognizing the presence of pain, identifying the characteristics of pain, and monitoring for effectiveness of interventions. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	See F697