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	01/05/2025

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on observation, interview, and record review, the facility failed to ensure facility staff notified the physician within four hours of receiving critical (values that are significantly outside the normal range) laboratory (labs) and/or the Medical Director (MD) if there was no response by the physician for one of three sampled residents (Resident 1). This deficient practice resulted in the facility's nursing staff receiving no instructions from Resident 1's physician related to Resident 1's critically high International Normalized Ratio ([INR] a blood test that measures how long it takes for blood to clot) results. This deficient practice had the potential to result in the need to significantly alter treatment. 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 the diagnosis of atrial fibrillation ([Afib] abnormally fast heartbeat that may lead to blood clots). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 11/10/2024, the MDS indicated Resident 1's cognition was severely impaired, and he was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on facility staff to complete his activities of daily of living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's undated Care Plan, the Care Plan indicated Resident 1 was at risk for bleeding and bruising secondary to anticoagulant therapy related to the use of Warfarin (a medication used to prevent blood clots from forming). The Care Plan' goals indicated Resident 1 would have no episodes of abnormal bleeding or extensive bruising. The Care Plan's interventions included carrying out labs as ordered and reporting abnormal results to the physician. During a review of Resident 1's laboratory results dated [DATE], the Laboratory Results indicated Resident 1's INR was 6.19 (INR range 2.0-3.0) and was flagged as critical. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Progress Note dated 12/2/2024, and timed at 9:38 p.m., the Progress Note indicated Resident 1's laboratory results were received, sent to Resident 1's physician and the facility was awaiting orders. Continued review of Resident 1's medical record indicated no evidence that facility staff attempted to contact Resident 1's physician after four hours of no response, as indicated in the facility policy and procedure (P/P) Critical Labs of Tests and Diagnostic Procedures-reporting of. During a review of Resident 1's laboratory results dated [DATE] and timed at 6:58 p.m., the Laboratory Results indicated Resident 1's INR was 5.83 and was flagged as critical. During a review of Resident 1's Progress Note dated 12/6/2024 and timed at 4:35 a.m., the Progress Note indicated Resident 1's INR result was relayed to Resident 1's physician, the facility staff were waiting for a response. The results of Resident 1's labs and status of the report to Resident 1's physician were endorsed to the next shift. Continued review of Resident 1's medical record indicated no evidence that facility staff attempted to contact Resident 1's physician after four hours of no response, as indicated in their P/P. During an interview on 1/2/2025 at 2:04 p.m., and a subsequent interview on 1/3/2025 at 12:15 p.m., LVN 1 stated when Resident 1's laboratory results indicated his INR level was high on 12/2/2024, the results were sent to Resident 1's physician. LVN 1 stated there was no response from Resident 1's physician and there was no follow up by facility staff with Resident 1's physician for instructions related to Resident 1's critical INR level. LVN 1 stated facility staff should have followed up with Resident 1's physician to determine if the laboratory results were received because the INR values were critically high, and Resident 1 was at risk for bleeding. During an interview on 1/4/2025 at 2:08 p.m., the DON stated licensed staff should report abnormal lab values to the physician within 24 hours, critical lab values should be reported within 4 hours, and if there was no response from the physician, the Medical Director (MD) should be contacted. During a review of the facility's P/P titled Critical Labs of Tests and Diagnostic Procedures-reporting of dated 1/2/2024, the P/P indicated the response including any new orders/interventions related to the critical results of tests and diagnostic procedures must occur within four (4) hours of the reporting of results. The P/P indicated if the Licensed Independent Practitioner (LIP) and or clinician responsible for the resident was not available and that LIP's alternate could not be reached or was unavailable, the Medical Director under which the LIP was privileged should be notified of the critical result.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, and record review, the facility failed to clarify an order for aspirin ([ASA] a medication used for mild pain relief and preventions of blood clots [a gel-like substance that forms when blood hardens from a liquid to a solid]) resulting in a discrepancy that was not clarified by licensed nursing staff for three months, for one of three sampled residents (Resident 1). Resident 1's physician ordered ASA, 81 milligrams ([mg] a metric unit of measurement, used for medication dosage and/or amount) by mouth, but the facility documented ASA 1 mg by mouth. As a result of this deficient practice Resident 1's ASA order was documented as follows: Administer ASA enteric coated (a coating designed to prevent medications from dissolving in the acidic environment of the stomach), delayed release (a type of medication that is designed to release the active ingredient later than immediately after administration) 81 mg. Give 1 mg by mouth one time daily for cerebrovascular accident ([CVA] a stroke, a condition where blood flow to the brain is blocked, leading to brain tissue damage) prevention. Instead of documentation that should have indicated to give 81 mg by mouth one time daily for CVA prevention. This deficient practice had the potential for staff confusion, misunderstanding of the physician's order and miscommunication of Resident 1's care needs. Findings: During a review of Resident 1 's Admission Record (Face Sheet), the Face Sheet documented that Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis of a cerebral infarction (a stroke). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 3/6/2025, the MDS documented that Resident 1's cognition (the process of thinking, attention, language, learning, memory and perception) was moderately impaired (a state where a resident has difficulty with certain aspects of daily life but can still function with some assistance or supervision). The MDS documented that Resident 1 used of an antiplatelet (a medication that prevents clots from forming) medication. During a review of Resident 1's Order Summary Report (Physician's Order), dated 2/28/2025, the Physician's Order documented that facility staff were to administer ASA, enteric coated, delayed release, 81 mg tablet and to give 1 mg by mouth one time a day for CVA prevention. During a review of Resident 1's Medication Administration Record (MAR), dated 2/2025, 3/2025 and 4/2025, the MAR included the following documentation: ASA, enteric coated, delayed release, 81 mg tablet, give 1 mg by mouth one time a day. The MAR indicated by initial of the licensed nursing staff that Resident 1's ASA was documented as administered from 2/1/2025 through 4/2/2025 at 9 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/2025 at 12:05 p.m., LVN 1 stated prior to administering medication, the correct medication, dose, time, and route of administration should be checked by the licensed nurses, by comparing the medication on hand with the physician's order. LVN 1 stated, if there were any discrepancies found, facility staff should clarify the order with the physician, and a new order should be obtained. LVN 1 stated during the morning medication administration (4/2/2025 at 9 a.m.) he administered one tablet of an 81 mg ASA enteric coated, delayed release medication to Resident 1. LVN 1 confirmed the order to give ASA 1 mg by mouth daily was a discrepancy and should have been clarified with the physician and corrected. During an interview on 4/2/2025 at 4:10 p.m., the Director of Nursing (DON) stated during medication administration, licensed nurses were expected to check and compare the medication on hand with the physician's orders, perform multiple checks that included checking the medication pack/container. The DON stated, if a discrepancy was found in the medication order, the licensed nurses were expected to notify the physician to obtain an order clarification. During a review of the facility's Policy and Procedure (P&P), titled, Administering Medications revised 4/2019, the P&P documented that if a dosage was believed to be inappropriate, the facility staff preparing or administering the medication would contact the prescriber, the resident's attending physician, or the facility's medical director to discuss the concerns. The facility staff administering the medication would check the medication label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration prior to administering the medication.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to ensure the Medication Regimen Review ([MRR] a thorough check of all the medications a patient is taking, done by a healthcare professional, to ensure they are safe, effective, and appropriate for their current health conditions) was conducted by the facility's Consulting Pharmacist (CP) for one of three sampled residents (Resident 1), to include a review of Warfarin (a medication used to prevent blood clots from forming), as well as Resident 1's labs. This deficient practice resulted in administration of unnecessary doses of Warfarin to Resident 1, placing Resident 1 at risk for adverse side effects of Warfarin, such as abnormal bleeding and/or excessive bruising. 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 the diagnosis of atrial fibrillation ([Afib] abnormally fast heartbeat that may lead to blood clots). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 11/10/2024, the MDS indicated Resident 1's cognition was severely impaired, and he was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on facility staff to complete his activities of daily of living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Physician's Order Summary Report dated 11/2024, the Physician's Order Summary Report indicated the following: 1. On 11/7/2024, Administer Warfarin 4.5 mg one time a day for Afib 2. On 11/19/2024 - Administer Warfarin 4.5 mg in the afternoon every Tuesday, Thursday, and Saturday for Afib, monitor for s/s of bleeding. 3. On 11/20/2024 - Administer Warfarin 4 mg, give one tablet in the afternoon every Monday, Wednesday, Friday, and Sunday for Afib, monitor for s/s of bleeding. During a review of Resident 1's the facility's Medication Regimen Review (MRR) dated 11/2024 and 12/2024, the MRR indicated there were no recommendations made by from the facility's CP regarding Resident 1's Warfarin administration or Resident 1's labs as they related to Warfarin's administration. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/3/2025 at 12:59 p.m., the Pharmacy Regional Director (PRD) stated Warfarin had a very narrow therapeutic range (when blood levels are in a range that is medically helpful but not dangerous) and the International Normalized Ratio ([INR] a blood test that measures how long it takes for blood to clot) levels should be closely monitored as well as possible drug interactions with other medications, the resident's diet and medical condition, all of which could affect the resident's INR level. The PRD stated the CP should look at every medication that was ordered for a resident including Warfarin and the resident's labs during the MRR. During an interview on 1/3/2025 at 3:46 p.m., the facility's CP stated during the facility's monthly MRR, he reviews all medications in the resident's medical record, the Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), and any significant laboratory results. The CP stated since Resident 1's Warfarin was dosed (prescribed) by Resident 1's physician, and he (the CP) was unaware of the physician's Warfarin dosing protocol he (the CP) could not make any recommendations related to the Warfarin. The CP stated the dosage and administration of Warfarin should be closely monitored because there was a risk of overdosing or under dosing the resident. The CP stated INR levels should be monitored daily until a therapeutic level is reached and adverse side effect such as bleeding and bruising should be monitored daily. During an interview on 1/4/2025 at 2:08 p.m., the DON stated when administering Warfarin, INR levels should be monitored because if the levels were out of the therapeutic range, residents could be at risk for bleeding or clotting (the process by which blood changes from a liquid to a solid to form a clot). The DON stated their CP pharmacy should review the administration of Warfarin even if the resident's physician ordered the dosage of the Warfarin. During a review of the facility's P/P titled Medication Regimen Review (MRR) dated 12/2019, the P/P indicated the consultant pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly. The P/P indicated the MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and preventing or minimizing adverse consequences related to medication therapy. The P/P indicated the MRR also involves thorough review of the resident's records and may include collaboration with other members of the IDT team. The P/P indicated at least monthly, the consultant pharmacist reports any irregularities to the attending physician, medical director, and director of nursing, at a minimum.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to ensure a resident, who was diagnosed with atrial fibrillation ([Afib] abnormally fast heartbeat that may lead to blood clots) and received Warfarin (a medication used to prevent blood clots from forming) was free from significant medication errors for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure Resident 1's Warfarin was administered as ordered by Resident 1's physician's Nurse Practitioner (NP). 2. Ensure licensed nurses did not administer multiple orders of duplicate therapy of Warfarin to Resident 1 on 11/21/2024, 11/22/2024, 11/23/2024, 11/25/2024 11/29/2024, 11/30/2024, 12/1/2024, 12/2/2024, 12/9/2024 and 12/10/2024 that included a dose of Warfarin that should have been discontinued on 11/19/2024. 3. Ensure licensed nurses monitored medication administration times and critical (values that are significantly outside the normal range) laboratory values to prevent and detect medication errors. These failures resulted in Resident 1's transfer to a General Acute Hospital (GACH) on 12/27/2024 where he was diagnosed with a subdural hematoma ([SDH] a collection of blood on the surface of the brain) measuring 12 millimeters ([mm] a metric unit of measurement, used for medication dosage and/or amount). Resident 1 upon admission to the GACH was intubated (insertion of a tube either through the mouth or nose and into the airway to aid in breathing) and administered Andexxa (a medication given to patients who are on anticoagulant medication [a class of drugs that help prevent blood clots and dissolve existing ones] to treat life-threatening or uncontrolled bleeding. On 1/4/2025 at 5:59 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 administer and monitor Resident 1's Warfarin medication according to the prescriber's order. On 1/5/2025, the facility submitted an acceptable IJ Removal Plan ([IJRP] interventions to immediately correct the deficient practices). After an onsite verification of the facility's IJRP's implementation through observation, interview, and record review, the IJ was removed on 1/5/2025 at 6:45 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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	a. On 1/4/2025, a comprehensive three-way audit of 13 medication carts was initiated with an expected completion date of 1/5/2025. This audit was conducted collaboratively by the Pharmacy and facility staff to ensure the following objectives were met; medications were administered correctly based on supply availability, medications availability, match of the medication blister pack/medication container to the physician orders, proper documentation, and medications that were revised previous orders were discontinued. Any issues identified were immediately corrected by the auditing nurse and communicated to the DON for review. b. On 1/5/2025, one on one education was provided to the Consulting Pharmacist ([CP] a licensed pharmacist who provides expert advice on the safe use and administration of medication), by the Pharmacy Regional Director of Operations (PRD). The session focused on the CP's role in conducting monthly drug regimen reviews for residents receiving anticoagulant medications. The key topics included the importance of monitoring medication administration times, critical lab values, and the pharmacist's collaborative role as part of the Interdisciplinary Team ([IDT] a group of medical professionals from different disciplines who work together to help a resident achieve their goals. c. On 1/5/2025, the Pharmacy Consultant conducted a Drug Regimen Review for 23 current residents who were receiving anticoagulant medication. Recommendations were communicated to the resident's physicians by the facility nursing staff and addressed accordingly. d. On 1/4/2025, a facility wide audit was conducted by the facility nursing staff for all residents utilizing the Anticoagulant Audit tool to ensure current residents receiving anticoagulant medication had orders to monitor for signs and symptoms (s/s) of bleeding every shift such as but not limited to: bleeding, discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy (a state of being drowsy and dull, listless, and unenergetic, indifferent and lazy, sluggish and inactive), bruising, sudden changes in mental status and/or vital signs (v/s), shortness of breath (SOB), or nose bleeds. The audit identified all current residents receiving anticoagulant therapy had routine monitoring of anticoagulant side effects. e. On 1/4/2025, a facility wide audit was conducted by the nursing staff to ensure proper administration of anticoagulant medications utilizing the Anticoagulant Audit tool The audit confirmed that all current residents who were prescribed anticoagulant medications were accurately identified, and no other residents were receiving those medications inappropriately. f. On 1/4/2025, the Assistant Regional Director of Clinical Services conducted a thorough chart review for 23 residents currently receiving anticoagulant medications. The review was undertaken to ensure the accuracy of medication orders, accurate monitoring of side effects with recommended frequency and to verify there were no instances of incorrect duplicate medications. g. On 1/4/2025 an in-service was initiated to licensed nurses by the DON focusing on the Anticoagulation Therapy Clinical Protocol including Warfarin's dosage, side-effects, significance of laboratory tests, and International Normalized Ratio ([INR] a blood test that measures how long it takes for blood to clot) therapeutic levels (level of medication in the blood to achieve its desired effect). (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	h. On 1/4/2025, the DON initiated an in-service for licensed nurses to address key medication management objectives. The training aimed to ensure the following: medications were administered correctly based on the available supply, availability of medication was verified, the medication blister packs or containers matched physician orders, proper documentation was maintained, and any medication changes were accompanied by the discontinuation of previous orders. The expected completion date for the in-service is January 5, 2025. Nurses who were unable to attend the session were instructed to report to the DON/designee during their next scheduled shift to receive the in-service. 1. On 1/4/2025, the DON initiated an in-service for licensed nurses focused on ensuring the accuracy of medication orders, proper monitoring of side effects at the recommended frequency, and verifying the absence of incorrect or duplicate medications. The in-service is expected to be completed by 1/5/2025. Nurses unable to attend the in-service were instructed to report to the DON/designee during their next scheduled shift to receive the in-service. j. On 1/4/2025, an in-service was provided initiated to licensed nurses by DON regarding policy and procedure on Medication Administration to ensure medications are administered per physician's order, orders are clarified if not available/not matching with supply at hand, and medications that were changed and have ongoing previous orders are clarified and discontinued. k. The Medical Director (MD) was notified of the IJ on 1/4/2025 at 6:45pm by the ADM. l. An Ad Hoc (when necessary or needed) Quality Assessment and Assurance ([QA&A] a group that ensures the quality of care and life in a facility by identifying and fixing quality issues) Committee meeting was scheduled for 1/5/2025, to discuss the IJRP. 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 a diagnosis of Afib. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 11/10/2024, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS indicated Resident 1 was dependent (helper does all the effort, resident does none of the effort to complete the activity) on facility staff to complete his activities of daily of living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's undated Care Plan, the Care Plan indicated Resident 1 was at risk for bleeding and bruising secondary to anticoagulant therapy related to the use of Warfarin. The Care Plan indicated labs should be completed as ordered and abnormal results should be reported to the physician. During a review of Resident 1's Physician's Order dated 11/5/2024, the Physician's order indicated Resident 1's Prothrombin ([PT] a factor in the blood that helps it clot properly)/INR was to be drawn on 11/7/2024 one time only. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During a review of Resident 1's Physician's Order Summary Report dated 11/7/2024, the Physician's Order Summary Report indicated to administer Warfarin 4.5 milligrams ([mg] unit of measurement) one time a day (9 a.m.) for Afib. During a review of Resident 1's Physician Order dated 11/7/2024, the Physician order indicated to draw Resident 1's INR on 11/10/2024. During a review of Resident 1's laboratory results dated [DATE], the Laboratory results indicated Resident 1's INR was 4.27 (INR range 2.0-3.0) and was flagged as critical. During a review of Resident 1's Change in Condition (COC) Note dated 11/13/2024, the COC note indicated Resident 1's INR was reported as 4.27 to Resident 1's physician, who ordered Vitamin K (a vitamin that plays a role in helping blood clot) 10 mg subcutaneous (beneath the skin) injection one time only, hold warfarin dose for two days, and repeat the INR test on 11/14/2024. During a review of the Laboratory Services Patient Care Log, the Laboratory Services Log indicated Resident 1 refused to have his blood drawn for his INR level on 11/14/2024 and 11/15/2024. During a review of Resident 1's laboratory results dated [DATE], the Laboratory results indicated Resident 1's INR was 1.18 and was flagged as abnormal (below the INR normal range of 2.0-3.0). During a review of Resident 1's Physician's Order Summary Report dated 11/2024, the Physician's Order Summary Report indicated the following: 1. On 11/19/2024 - Administer Warfarin 4.5 mg in the afternoon every Tuesday, Thursday, and Saturday for Afib, monitor for s/s of bleeding. 2. On 11/19/2024 - Resident 1 may have PT and INR levels drawn every Tuesday and Thursday. 3. On 11/20/2024 - Administer Warfarin 4 mg, give one tablet in the afternoon every Monday, Wednesday, Friday, and Sunday for Afib, monitor for s/s of bleeding. During a review of Resident 1's laboratory results dated [DATE], the Laboratory results indicated Resident 1's INR was 1.12 and was flagged as abnormal. During a review of Resident 1's Nursing Note, dated 11/22/2024 and timed at 8:59 p.m., the Nursing Note indicated Resident 1's laboratory results dated [DATE] were sent to Resident 1's physician. The Nursing Note indicated there was no response from the physician. During a review of Resident 1's Nursing Note dated 11/23/2024 and timed at 7:41 a.m., the Nursing Note indicated the facility refaxed Resident 1's INR results to Resident 1's Physician. The Nursing Note indicated there was no new order, the facility staff endorsed this to the next shift. During a review of Resident 1's Medication Administration Record (MAR) dated 11/2024, the MAR indicated Resident 1's administration of Warfarin as follows: The 9 a.m., dose of Warfarin should have been discontinued, per Resident 1's Physician's NP. (continued on next page)

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	01/05/2025

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.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	1. On 11/21/2024 - Warfarin 4.5 mg was administered to Resident 1 at 9 a.m. and 5 p.m. (a total of 9 mg). 2. On 11/22/2024 - Warfarin 4.5 mg was administered to Resident 1 at 9 a.m., and 4 mg was administered to Resident 1 at 5 p.m. (a total of 8.5 mg). 3. On 11/23/2024 - Warfarin 4.5 mg was administered to Resident 1 at 9 a.m., and 5 p.m. (a total of 9 mg). 4. On 11/25/2024 Warfarin 4.5 mg was administered to Resident 1 at 9 a.m., and 4 mg was administered to Resident 1 at 5 p.m. (a total of 8.5 mg). 5. On 11/29/2024 Warfarin 4.5 mg was administered to Resident 1 at 9 a.m., and 4 mg was administered to Resident 1 at 5 p.m. (a total of 8.5 mg). 6. On 11/30/2024 Warfarin 4.5 mg was administered to Resident 1 at 9 a.m. and 5 p.m. (a total of 9 mg). During a review of Resident 1's laboratory results dated [DATE], the Laboratory results indicated Resident 1's INR was 6.19 and was flagged as critical. During a review of Resident 1's Progress Note dated 12/2/2024, and timed at 9:38 p.m., the Progress Note indicated Resident 1's INR results of 6.19 were received and sent to Resident 1's physician and the facility was awaiting orders. Resident 1's lab results and the physician's pending response were endorsed to the next shift. There was no physician response. During a review of Resident 1's laboratory results dated [DATE] and timed at 6:58 p.m., the Laboratory results indicated Resident 1's INR was 5.83 and was flagged as critical. During a review of Resident 1's Progress Note dated 12/6/2024 and timed at 4:35 a.m., the Progress Note indicated Resident 1's INR results of 5.83 was relayed to Resident 1's physician, and the staff were waiting for a response. During a review of Resident 1's MAR dated 12/2024, the MAR indicated Warfarin was administered to Resident 1 as follows: The 9 a.m., dose of Warfarin should have been discontinued, per Resident 1's Physician's NP. 1. On 12/1/2024 - Warfarin 4.5 mg was administered to Resident 1 at 9 a.m., and 4 mg of Warfarin was administered to Resident 1 at 5 p.m. (a total of 8.5 mg). 2. On 12/2/2024 - Warfarin 4.5 mg was administered to Resident 1 at 9 a.m., and 4 mg of Warfarin was administered to Resident 1 at 5 p.m. (a total of 8.5 mg). 3. On 12/9/2024 - Warfarin 4.5 mg was administered to Resident 1 at 9 a.m., and 4 mg of Warfarin was administered to Resident 1 at 5 p.m. (a total of 8.5 mg). 4. On 12/10/2024 - Warfarin 4.5 mg was administered to Resident 1 at 9 a.m., and 5 p.m. (a total of 9 mg). (continued on next page)

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	555565	A. Building B. Wing	01/05/2025

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During a review of Resident 1's Physician's Orders dated 12/11/2024, the Physician's Orders indicated to discontinue administration of Warfarin. During a review of the Resident 1's Physician's Order dated 12/13/2024, the Physician's Order indicated to administer Eliquis (an oral anticoagulant that helps prevent and treat blood clots) 5 mg two times a day for DVT ([deep vein thrombosis] occurs when a blood clot forms in one or more of the deep veins in the body, usually in the legs) prophylaxis (preventative treatment against disease). During a review of Resident 1's MAR dated 12/2024, the MAR indicated Resident 1 received Eliquis as ordered from 12/13/2024 thru 12/27/2024. During a review of Resident 1's Nurse's Note dated 12/27/2024, the Nurse's Note indicated Certified Nursing Assistant 1 (CNA 1) observed Resident 1 sitting in a wheelchair, not talking. The Nurse's Note indicated Resident 1 was assessed and 911 emergency services was called. The Nurse's Note indicated Resident 1 was transferred to the GACH for further intervention and assessment. During a review of Resident 1's Physician's Orders dated 12/27/2024, the Physician's Orders indicated to transfer Resident 1 to the nearest GACH via 911 due to unresponsiveness. During a review of the GACH's Emergency Physician's note dated 12/27/2024, the Emergency Physician's note indicated Resident 1 was brought to the GACH via ambulance with a chief complaint of a SDH that measured 12 millimeters ([mm] a unit of measurement). The Emergency Physician's note indicated Resident 1 was intubated and administered Andexxa for reversal of Eliquis. During an interview on 1/2/2025 at 2:04 p.m., and a subsequent interview on 1/3/2025 at 12:15 p.m., Licensed Vocational Nurse (LVN) 1 stated Resident 1 received multiple doses of Warfarin that overlapped beginning on 11/19/2024. LVN 1 stated when Resident 1's laboratory results indicated his INR level was critically high on 12/2/2024, the results were sent to the physician but there was no follow up by facility's staff when Resident 1's physician did not respond to the fax. LVN 1 stated the staff should have followed up with the physician to determine if the laboratory results were received because the INR values were critically high, and Resident 1 was at risk for bleeding. During an interview on 1/2/2025 at 4:18 p.m., LVN 2 stated all lab results should be reported to the physician and a response from the physician was expected by the end of the shift. LVN 2 stated, if there was no response from the physician by the end of the shift, the lab results should be reported to the MD. During an interview on 1/2/2025 at 4:41 p.m., the NP stated when she revised the Warfarin order to indicate it should be administered to Resident 1 on alternating days of the week (11/19/2024), she instructed LVN 2 to discontinue the order for Warfarin 4.5 mg daily. The NP stated she was not aware Warfarin 4.5 mg daily order was still active. The NP stated Warfarin had a very narrow therapeutic range and Resident 1's INR level could be affected if Warfarin was not administered as ordered and closely monitored. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 1/4/2025 at 1:18 p.m., the MD stated he had no knowledge that Resident 1's physician had not responded to a report of critical INR levels and was only aware of Resident 1's condition on 12/30/2024, when the GACH reported that Resident 1 sustained an SDH. The MD stated Warfarin was a complicated medication to administer because it involved constant monitoring, blood tests, dose adjustments, and daily monitoring for side effects such as bleeding and bruising. The MD stated if a resident's INR was low, there was a risk that the resident could develop blood clots and if the INR was too high, there was a risk that the resident could develop bleeding. During an interview on 1/4/2025 at 2:08 p.m., the DON stated when administering Warfarin, INR levels should be monitored because if the levels were out of the therapeutic range, residents could be at risk for bleeding or clotting. The DON stated licensed staff should report abnormal lab results to the physician within 24 hours, and critical lab results should be reported to the physician within 4 hours. The DON stated if there was no response from the physician, the MD should be contacted. The DON stated Resident 1's Warfarin 4. 5 mg daily order should have been discontinued on 11/19/2024 when the revised Warfarin order was received. During an interview on 1/4/2025 at 2:47 p.m., the ADM stated the licensed nurses documented they administered Warfarin 4.5 mg daily (9 a.m.) in error and they did not administer Warfarin to Resident 1, so Resident 1 could not have received extra doses of Warfarin. During a review of the facility's Policy and Procedure (P/P), titled Administering Medications dated 2001, the P/P indicated medications were administered in accordance with the prescriber's orders, including any required time frame. During a review of the facility's P/P titled Critical Labs of Tests and Diagnostic Procedures-Reporting of dated 1/2/2024, the P/P indicated the response including any new orders/interventions related to the critical results of tests and diagnostic procedures must occur within four (4) hours of reporting of results. The P/P indicated if the Licensed Independent Practitioner ([LIP] a health care provider who is legally permitted to provide care without direct supervision) and or clinician responsible for the resident is not available and that LIP's alternate cannot be reached or is unavailable, the medical director under which the LIP is privileged shall be notified of the critical result.