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	05/23/2025

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a written notice Based on interview, and record review, the facility failed to ensure a written copy of the bed hold notice was created and provided to two of two sampled resident's (Residents 1 and 2) responsible parties (RP 1 and RP 2) within 24 hours of transferring Resident 1 and Resident 2 to a General Acute Care Hospital (GACH). This deficient practice resulted in the incomplete status of Resident 1 and Resident 2's bed hold availability and no documented notice provided to RP 1 and RP 2. Findings: a. 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 paranoid schizophrenia (a type of schizophrenia characterized by false beliefs of being persecuted, harmed, or spied upon) and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set ([MDS] a standardized resident assessment tool) dated 4/1/2025, the MDS indicated Resident 1 had moderately impaired cognition (a noticeable but not severe decline in thinking, learning, remembering, using judgment, and making decisions) and required supervision (helper provides verbal cues and/or touching /steadying to complete the activity) to complete activities of daily living ([ADL] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Progress Note, dated 5/19/2025 and timed at 2:56 p.m., the Progress Note indicated Resident 1 was transferred to a GACH for further assessment and clearance. During a review of Resident 1's Progress Note, dated 5/20/2025 and timed at 10 a.m., the Progress Note indicated the Social Services Director (SSD) contacted RP 1 to inform them of the seven-day bed hold policy. During a review of Resident 1's Medical Record, the Medical Record indicated no documented evidence that a written Bed Hold notice was created. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/23/2025 at 3 p.m., with the SSD, Resident 1's Bed Hold Informed Consent was reviewed. The SSD stated RP 1 was notified upon Resident 1's admission to the facility (5/22/2025) of the facility's bed hold policy. The SSD stated RP 1 was notified verbally on 5/19/2025 at the time Resident 1 was transferred to the GACH but was unable to show documented evidence that a Bed Hold notice was created and provided to RP 1 within 24 hours of Resident 1's transfer to the GACH b. During a review of Resident 2's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including dementia. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had impaired cognition and required partial/moderate assistance (helpers does less than half the effort) to complete ADLs. During a review of Resident 2's Progress Note, dated 5/19/2025 and timed at 2:56 p.m., the Progress Note indicated Resident 2 was transferred to a GACH for further assessment and clearance. During a review of Resident 2's Progress Note, dated 5/20/2025 and timed at 10 a.m., the Progress Note indicated the SSD contacted RP 2 to inform them of the seven-day bed hold policy. During a concurrent interview and record review on 5/23/25 at 3 p.m., with the SSD, Resident 2's Bed Hold Informed Consent was reviewed. The SSD stated RP 2 was notified upon Resident 2's admission to the facility (5/22/2025) of the facility's bed hold policy. The SSD stated RP 2 was notified verbally on 5/19/2025 at the time Resident 2 was transferred to the GACH but was unable to show documented evidence that a Bed Hold notice was created and provided to RP 2 within 24 hours of Resident 2's transfer to the GACH. During a review of the facility's Policy and Procedure (P&P), titled Bed-Holds and Returns dated 1/2025, the P&P indicated all residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave) . at the time of transfer (or, if the transfer was an emergency, within 24 hours).

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure neurological (relating to disorders of the nervous system) assessments was completed, per protocol, for one of three sampled residents (Resident 3), after Resident 3 experienced a fall and hit his head. This deficient practice resulted in an incomplete/incorrect neurological assessment of Resident 3 and had the potential for a change of condition (COC) to go unnoticed which could lead to a delay in evaluation and care. Findings: During a review of Resident 3's admission Record (Face Sheet), the Face Sheet indicated Resident 3 was readmitted to the facility on [DATE] with diagnoses including Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and muscle weakness. During a review of Resident 3's Minimum Data Set ([MDS] a standardized resident assessment tool) dated 5/1/2025, the MDS indicated Resident 3 had severely impaired cognition (a very hard time remembering things, making decisions, concentrating, or learning) and required partial/moderate assistance (helper does less than half the effort to complete the activity) to complete activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 3's Progress Note, dated 5/8/2025 and timed at 12:30 a.m., the Progress Note indicated Resident 3 experienced an unwitnessed fall in his room and suffered a cut on his left eyebrow. The Progress Note indicated Resident 3's physician was notified and instructed staff to conduct a neuro checks. During a concurrent interview and record review on 5/21/2025 at 6:15 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 3's Neurological Assessment Flowsheet dated 5/8/2025 and 5/9/2025 was reviewed. The Neurological Assessment Flowsheet indicated the neurological checks were to be conducted as follows: Every 15 minutes times four Every 30 minutes times two Every hour times two Every four hours times four Every eight hours times six Continued review of the Neurological Assessment Flowsheet indicated there were 11 missed neurologic assessments. Resident 3's neurological assessments were conducted as follows: On 5/8/2025: 12:30 a.m., 12:45 a.m., 1 a.m., 1:15 a.m. 1:45 a.m., 2:15 a.m. 3:15 a.m., 4:15 a.m. 12:15 p.m., 2:12 p.m., 5:12 p.m., 9:12 p.m., (the 8:15 a.m., 4:15 p.m., and 8:15 p.m., assessments were missed) On 5/9/2025: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5 a.m., 7 a.m., 1 a.m., 2 p.m., 5 p.m., and 11 p.m., (the 4:15 a.m., 12:15 p.m., 8:15 p.m., 5/10/2025 at 4:15 a.m., 12:15 p.m., 8:15 p.m., 5/11/2025 at 4:15 a.m., and 12:15 p.m., assessments were missed) LVN 1 stated she thought she documented Resident 3's neurologic assessment correctly but when pointed out the times of assessment that were incorrect she could not explain why. During a concurrent interview and record review on 5/21/25 at 8:05 a.m., with the Director of Nursing (DON), Resident 3's Neurological Assessment Flowsheet dated 5/8/2025 and 5/9/2025 was reviewed. The DON verified the neurological assessment was done incorrectly, and stated the neurological assessment schedule should have been followed per the instructions on the Neurological Assessment Flowsheet. During a review of the facility's Policy and Procedure (P/P), titled, Neurological Assessment (Routine) revised 10/2023, the P/P indicated routine neurological assessment is conducted to evaluate the resident for small changes over time that may be indicative of neurological injury. Steps in the procedure include to conduct neurological checks as frequently as ordered.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on interview and record review, the facility failed to ensure two of nine sampled residents (Resident 1 and Resident 2), who were assessed at risk for elopement (the act of leaving a facility unsupervised and without prior authorization), received supervision to prevent elopement from the facility. These deficient practices resulted in Resident 1 and Resident 2 eloping from the facility on 5/18/2025 at approximately 12 p.m. without staff awareness. Resident 1 and Resident 2 were located by Resident 1's Family Member (FM) 1 approximately 20 miles from the facility on 5/19/2025 at approximately 3 p.m. (approximately 27 hours after they were believed to have eloped from the facility). Both residents were transported to a General Acute Care Hospital (GACH) for evaluation and treatment, where they remained for four days. Resident 1 was admitted to the GACH with altered mental status (a change from a person's normal mental state) and Resident 2 was assessed and treated for a urinary tract infection ([UTI] an infection in the bladder/urinary tract). These deficient practices placed Resident 1 and Resident 2 at risk of exposure to inclement weather (unpleasant or severe weather conditions that can disrupt activities, create hazardous situations, or pose risks to safety), vehicular accident and injury, harm by other individuals and death, and placed 144 residents, who resided in the facility, and who were assessed as high risk for wandering/elopement, at risk for elopement from the facility. On 5/20/2025 at 7:03 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 identify Resident 1 and Resident 2 prior to allowing them entry into the facility's lobby from a locked unit and permitting them to elope the building through the facility's front door. On 5/23/2025, 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 5/23/2025 at 3:06 p.m., in the presence of the facility's DON and ADM. The facility's IJRP included the following immediate actions: On 5/19/2025 - 5/20/2025 a review 228 residents' medical records was conducted by the DON and IDT members to ensure each resident had an updated Elopement/Wandering Risk assessment and care plan. 144 residents were identified at risk for elopement/wandering. 10 of the 144 at risk residents were identified with no elopement risk/wandering care plans, their care plans were updated to reflect interventions to ensure residents were free from elopement episodes and free from any injuries if wandering. An Elopement binder located at the receptionist desk and in Point Care Click ([PCC] a healthcare management platform designed to simplify resident care and improve efficiency in senior care facilities) Special Instructions (a mechanism in PCC to identify if a resident is at risk for elopement/wandering) were updated on 5/20/2025 to reflect residents' appropriate risk for elopement/wandering. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/18/2025, the Infection Preventionist Nurse (IPN) Nurse Manager and Regional Director of Clinical Services (RDCS) initiated an in-service for the licensed nursing staff regarding the facility's policy and procedure on elopements, and emergency procedure when a resident is missing/has eloped. On 5/19/2025 an In-service was initiated by the DSD for facility staff regarding residents at risk for elopement, identifying wandering and exit seeking behaviors, interventions for wandering and exit seeking behaviors, new visitor screening process for visitors/outside providers, new staff entrance/exit process, staff/visitor/outside providers' badges are visible and any individuals without proper badge/identification will not be permitted entry or exit through the locked doors, when opening locked doors ensure residents are not following them, vigilance in noticing surroundings when entering or leaving locked doors. Staff are no longer permitted to enter or exit through the front doors to lessen crowding and increase visibility. Staff will begin utilizing the metal doors located East of the front entrance at the front of the facility. A sign has been placed on the front door directing staff to the new entrance location. All staff will enter the facility through an alternative entrance on the day and evening shifts, and after hours, staff entering the building will press a button and staff inside the building, after viewing a camera, will let them in. Two receptionists are currently assigned to screen visitors from 7 a.m. - 7 p.m., at the front lobby daily Monday through Sunday. During lunch breaks, the two receptionist will relieve each other, there will be only one receptionist during lunch breaks. On 5/20/2025 the facility upgraded entrance doors with a magnetic security/closure function in addition to a keypad entry that was installed. On 5/19/2025 the Receptionist and CNA involved were placed on leave pending the outcome of the investigation. The Receptionist and CNA's termination will be processed effective 5/23/2025. The DSD/designee will conduct hallway rounds three times per week to ensure residents are supervised and redirected to appropriate units. 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 paranoid schizophrenia (a type of schizophrenia [a mental illness that affects a person's thoughts, feelings and behaviors] marked primarily by distrust of others, and false beliefs of being persecuted, harmed, or spied upon) and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 4/1/2025, the MDS indicated Resident 1 had moderately impaired cognitive skills (problems with a person's ability to think, learn, remember, use judgement, and make decisions) for daily decision making and required supervision (helper provides verbal cues and/or touching /steadying to complete the activity) to complete activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Wandering Risk Observation/assessment dated [DATE], the Wandering Risk Observation/Assessment indicated a score of nine indicating Resident 1 was at risk for wandering. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's untitled Care Plan dated 4/23/2025, the Care Plan indicated Resident 1 was an elopement risk/wanderer related to her attempts to leave the facility unattended. Under this Care Plan, the goal was that Resident 1 would not leave the facility unattended through the review date of 6/23/2025. The Care Plan's interventions included distracting Resident 1 from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books, monitoring Resident 1's location every two hours and document wandering behavior and attempted diversional interventions in the behavior log. During a review of Resident 1's Change of Condition (COC) form dated 5/18/2025, the COC indicated on 5/18/2025 at approximately 5:41 p.m., Resident 1 could not be located anywhere in the facility and Code Black was initiated. The COC indicated at 5:41 p.m., the DON, ADM, local police and Resident 1's Responsible Party (RP) were notified of Resident 1's disappearance. During a review of Resident 1's Nursing Progress Note dated 5/19/2025 and timed at 2:56 p.m., Family Member (FM) 1 reported he located Resident 1 near his residence. The Nursing Progress Note indicated Resident 1 was transported to a GACH by the facility's ADM and SSW for assessment and clearance. During a review of Resident 1's Face Sheet, the Face Sheet indicated Resident 1 was admitted to the GACH on 5/19/2025. During a review of the GACH's Emergency Department (ED) Progress Note dated 5/19/2025, the ED Progress Note indicated Resident 1 was admitted with a diagnosis of altered mental status. During a review of Resident 2's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of dementia. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had impaired cognitive skills for daily decision making and required partial/moderate assistance (helpers does less than half the effort) to complete ADLs. During a review of Resident 2's Wandering Risk Observation/assessment dated [DATE] the Wandering Risk Observation/Assessment indicated a score of eleven indicating Resident 2 was a high risk for wandering. During a review of Resident 2's untitled Care Plan dated 9/5/2024, the Care Plan indicated Resident 2 was an elopement risk/wanderer related to disorientation to place and impaired safety awareness. The care plan indicated Resident 2 wandered aimlessly and significantly intruded on the privacy or activities of others. Under this Care Plan, the goal was that Resident 2 would not leave the facility unattended through the review date of 12/04/2024. The Care Plan's interventions included monitoring Resident 2's location, documenting wandering behavior and attempted diversional interventions in the behavior log. During a review of Resident 2's COC dated 5/18/2025, the COC indicated on 5/18/2025 at approximately 5:41 p.m., Resident 1 could not be located anywhere in the facility and Code Black was initiated. The COC indicated at 5:41 p.m., the DON, ADM, local police and Resident 2's RP were notified of Resident 2's disappearance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 2's Nursing Progress Note dated 5/19/2025 and timed at 2:56 p.m., the Nursing Progress Note indicated FM 1 reported he located Resident 2 near his residence. The Nursing Progress Note indicated Resident 2 was transported to a GACH by the facility's ADM and SSW worker for assessment and clearance. During a review of Resident 2's Face Sheet, the Face Sheet indicated Resident 2 was admitted to the GACH on 5/19/2025. During a review of the GACH's ED Progress Note dated 5/19/2025, the ED Progress Note indicated Resident 2 was admitted to the GACH with a diagnosis of urinary tract infection, and diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar [b/s] control and poor wound healing). During an interview on 5/20/2025 at 10:56 a.m., and a subsequent interview at 12:42 p.m., RCP 1 stated on 5/18/2025 at approximately 12:10 p.m. to 12:15 p.m., CNA 1 rang the doorbell from inside the facility's locked area alerting her (RCP 1) to unlock the door, which led to the facility's lobby area, so that the visitors (Resident 1 and Resident 2) could be allowed out. RCP 1 stated she unlocked the door, and Resident 1 and Resident 2 entered the lobby and continued out the facility's front entrance. RCP 1 stated Resident 1 and Resident 2 did not have on green visitors stickers, but she stated that was not uncommon because visitors entered the facility through a different entrance when she was on her lunch break. RCP 1 stated she found out later that evening, those visitors were residents. RCP 1 stated she was not familiar with the residents in the facility, and she did not recognize the visitors were actually residents. RCP 1 stated there was no process to check out visitors when they left the facility, she just told Resident 1 and Resident 2 goodbye and have a nice day when they left out of the building through the facility's front door. During an interview on 5/20/2025 at 11:48 a.m., CNA 1 stated on 5/18/2025 at approximately lunchtime she was passing by the locked doors that led to the facility's lobby area and saw two ladies that did not look like residents near the doors. CNA 1 stated she pressed the button (doorbell) to signal for RCP 1 to unlock the doors, which she (RCP 1) did, and the two ladies proceeded into the lobby area. CNA 1 stated she saw one of the two ladies wearing a green visitor sticker which was given to visitors when they enter the facility. During an interview on 5/20/2025 at 2:42 p.m., CNA 4 stated on 5/18/2025 at approximately lunchtime, she did not see Resident 1 or Resident 2 when she delivered lunch trays to their shared room. CNA 4 stated she does rounds on her assigned residents every two hours, during her rounds on 5/18/2025, she did not see Resident 1 and Resident 2 after delivering their lunch trays and did not look for them because she assumed they were on the facility's patio. CNA 4 stated she did notice their lunch trays were still in the resident's room and were untouched. CNA 4 stated she found out later that night, Resident 1 and Resident 2 were missing from the facility. During an interview on 5/20/2025 at 2:15 p.m., CNA 5 stated when she started her shift at 3 p.m., on 5/18/2025 she noticed Resident 1 and Resident 2's lunch trays were still in their room untouched. CNA 5 stated she asked staff members if they had seen the residents, but nobody had seen them. CNA 5 stated prior to dinner time (unsure of the exact time), she asked other staff to help her look for Resident 1 and Resident 2 and they (her and the other staff) continued looking for them through dinner time. CNA 5 stated she found out the residents had eloped when she heard Code Black (an alert to facility staff to initiate a search of the building and premises for a resident who left the facility without authorization), being activated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/20/2025 at 3:04 p.m., the DON stated Resident 1 and Resident 2's whereabouts in the facility should have been monitored every two hours because they were high risk for wandering/elopement. The DON stated staff should have confirmed if the two ladies (Resident 1 and Resident 2) were actual visitors prior to allowing them into the facility's lobby area and then allowing them to exit through the facility's front door. The DON stated the facility had no check out process for visitors and none was utilized by RCP 1 prior to Resident 1 and Resident 2 eloping from the facility. The DON stated the residents' elopement placed them at risk for harm by car accident and/or injury by other individuals, missed medications, no access to food or water, and exposure to different weather conditions. During a review of the facility's undated Policy and Procedure (P/P) titled Wandering Residents and Elopements the P/P indicated the facility maintains a process to assess residents for elopement risk, or who are at risk of unsafe wandering and will implement risk reduction strategies. The P/P indicated interventions that may be used for residents identified as high risk for elopement include but may not be limited to the physical plant is secured to minimize the risk of elopement through safety locks or keypad entry that restrict access to dangerous areas.

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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 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** Based on interview and record review, the facility failed to create and document a Nursing Fall Assessment when one of three sampled residents (Resident 3) experienced a fall and injury to his left eyebrow. This deficient practice resulted in no documented interventions for Resident 3 following his fall and left eyebrow injury and had the potential for care not to be rendered and/or monitored. Findings: During a review of Resident 3's admission Record (Face Sheet), the Face Sheet indicated Resident 3 was readmitted to the facility on [DATE] with diagnoses including Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and muscle weakness. During a review of Resident 3's Minimum Data Set ([MDS] a standardized resident assessment tool) dated 5/1/2025, the MDS indicated Resident 3 had severely impaired cognition (a very hard time remembering things, making decisions, concentrating, or learning) and required partial/moderate assistance (helper does less than half the effort to complete the activity) to complete activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 3's Progress Note, dated 5/8/2025 and timed at 12:30 a.m., the Progress Note indicated Resident 3 experienced an unwitnessed fall in his room and suffered a cut on his left eyebrow. The Progress Note indicated Resident 3's physician was notified and instructed staff to monitor Resident 3 and conduct a neuro checks. During a concurrent interview and record review on 5/23/2025 at 8:05 a.m., with the Director of Nursing DON, Resident 3's Medical Record was reviewed. Resident 3's Medical Record indicated there was no documented evidence that a Nursing Fall Assessment was conducted when Resident 3 fell on 5/8/2025 and sustained an injury to his left eyebrow. The DON stated when a resident experiences a fall, a licensed nurse should complete a Nursing Fall Assessment so that staff will know which interventions to put into place. During a review of the facility's Policy and Procedure (P/P), titled, Falls and Fall Risk, Managing dated 3/2018, the P/P indicated 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

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	05/23/2025

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interview and record review, the facility failed to provide training related to resident elopement (the act of leaving a facility unsupervised and without prior authorization) for eight of eight sampled employees (Certified Nursing Assistants [CNA] 1, 8, 9, 10, 11, 12 and 13 and a Restorative Nursing Assistant (RNA 1) on hire and/or annually, as indicated in their Facility Assessment. This deficient practice resulted in CNA 1 and Receptionist (RCP) 1 allowing two residents (Resident 1 and Resident 2) to enter the facility's lobby area from a locked location and then wander (a situation in which a resident leaves the premises of a safe area without the facility's knowledge and supervision, if necessary, would be considered and elopement) through the facility's front door on 5/18/2025. Findings: During a review CNAs 1, 8, 9, 10, 11, 12, 13, and RNA 1's Employee Files, the Employee files indicated there was no documented evidence that the forementioned employees received training related to resident elopement. During an interview on 5/22/2025 at 9:40 a.m., and a subsequent interview at 10:12 a.m., the Director of Staff Development (DSD) stated new hire training covered the topic of Code Black (an alert to facility staff to initiate a search of the building and premises for a resident who left the facility without authorization), but did not include training regarding interventions to prevent residents' from elopement or how to identify a resident versus a visitor. The DSD stated elopement training was not a mandatory topic, and she was focused on other topics for CNAs to complete their training hours. During an interview on 5/22/2025 at 11:46 a.m., the Director of Nursing (DON) stated he believed training related to resident elopement was ongoing (but it was not). The DON stated staff should have received elopement education upon hire, annually and as needed. During a review of the facility's Facility assessment dated 6/2024, the Facility Assessment indicated staff training/education and competencies that were necessary to provide the level and types of support and care needed for the resident population included CNA skills, competency and review on the topic of residents who are at risk for elopement/wandering.