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	11/25/2025

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 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. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Certified Nursing Assistant (CNA) 1, who discovered a resident on the floor, following an unwitnessed fall (8/21/2025), reported the resident's fall and did not place the resident back in bed prior to a licensed nurse's assessment for one of three sampled residents (Resident 1) reviewed for falls. When the facility was made aware of Resident 1's unwitnessed fall, they failed to conduct a neurological (a series of simple tests to see how well your brain, spinal cord, and nerves are working) assessment, per their policy and procedure (P/P) titled, Neurological Assessment (Routine). These deficient practices resulted in a delay in care (assessment, pain management, evaluation) and transfer to a General Acute Care Hospital (GACH) on 8/22/2025 for continued evaluation and treatment. These deficient practices had the potential for unrecognized injuries as well as unrecognized changes in Resident 1's neurological status. Findings: a. During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures [involuntary muscle movements]). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 7/21/2025, the MDS indicated Resident 1's cognition (ability to think, understand, learn, and remember) was moderately impaired and required moderate assistance (helper does less than half the effort) with activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of the facility's Investigation Binder, dated 8/22/2025 and timed at 12:45 a.m., the Investigation Binder indicated CNA 1 documented, Resident 1 was trying to get into bed, then assisted him back into his bed. Continued Documentation in the Investigation Binder by Licensed Vocational Nurse (LVN) 2 indicated, Resident 1 reported that he rolled out of bed, fell to the floor and then began to get up by himself. Resident 1 reported the assigned CNA (CNA 1) saw him while trying to go back to bed and assisted him. During an interview on 9/16/2025 at 9:50 a.m., Resident 1 stated he rolled off his bed onto the floor, there were no staff was present, but stated a female employee (CNA 1) came in and assisted him back to bed. Resident 1 stated he told another staff (LVN 2) later that afternoon he had fallen. During an interview on 9/17/2025 at 11:18 a.m., the Assistant Director of Nursing (ADON) stated he was not made aware of Resident 1's fall until 5 p.m., on 8/21/2025 when Registered Nurse Supervisor (RNS) 2 reported it to him. The ADON stated he should have conducted a more thorough investigation of Resident 1's unwitnessed fall. During an interview on 9/17/2025 at 1:34 p.m., LVN 2 stated if Resident 1 was assisted back to bed by CNA 1, CNA 1 should have reported it to the supervisor. LVN 2 stated, she was first made aware of Resident 1's fall when Resident 1 informed her at approximately 5 p.m., on 8/21/2025 that he had fallen at 1 p.m., that afternoon (8/21/2025) and she immediately reported it to her supervisor. During a review of the facility's Certified Nurse Assistant (CNA) Job Description, the CNA Job Description indicated, Report all changes in the resident's condition to the Nurse Supervisor/Charge Nurse as soon as practicable. Report all accidents and incidents you observe on the shift they occur. The facility was unable to provide a P/P indicating steps to take when a resident is found on the floor. b. During an interview on 9/17/2025 at 8:11 a.m. , LVN 3 stated a neurological check should be done following a resident's fall to monitor and assess for possible cognitive changes in the resident. During a concurrent interview and record review on 9/17/2025 at 10:45 a.m., with the Medical Records Supervisor (MRS), the MRS provided Resident 1's Neurological Assessment, which indicated Resident 1's neurological assessment was not initiated after Resident 1's fall was reported to LVN 2 on 8/21/2025 at 5 p.m., and prior to Resident 1's transfer to the GACH on 8/22/2025. During a concurrent interview on 9/17/2025 at 11:18 a.m., after reviewing Resident 1's Neurological Assessment, the ADON stated Resident 1's neurological status was not assessed after learning he had fallen, but it should have been done. The ADON stated neurological checks were important because they identified abnormalities in the resident's cognitive function which could possibly lead to a stroke (occurs when blood flow to the brain is interrupted) or a bleed in the brain. During an interview on 9/17/2025 at 2:24 p. m., the Director of Nursing (DON) stated a neurological assessment should be initiated after an unwitnessed fall or trauma to the head and one should have been initiated for Resident 1 after learning he had fallen. During a review of the facility's P/P, titled, Neurological Assessment (Routine) dated 1/2025, the P/P