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	03/19/2026

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 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 ensure facility staff accurately documented in the clinical record for one of five sampled residents (Resident 1) when Resident 1 had multiple prior attempts to elope (an unauthorized departure of a patient from an around-the-clock care setting) from the facility, but documentation indicated he did not attempt to elope.This failure of inaccurate documentation posed a risk for staff not identifying Resident 1 as an elopement risk, which could delay timely interventions and place Resident 1 at risk for injury or death due to unsupervised exit from the facility.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]. Resident 1 had diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), dementia (a progressive state of decline in mental abilities) and generalized anxiety disorder (a mental health condition where a person experiences excessive, persistent worry or fear that is out of proportion to the situation and hard to control, interfering with daily life).During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 9/21/2025, 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 and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance) from staff for his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Situation, Background, Assessment, Recommendation ([SBAR] a communication tool used by healthcare workers when there is a change of condition among the residents) dated 9/14/2025 and timed at 7:03 a.m., the SBAR indicated Resident 1 was observed attempting to jump over a facility fence. Facility staff (unknown) immediately approached Resident 1 and redirected him away from the area.During a review of Resident 1's Elopement and Wandering Risk Observation/Assessment form dated 9/14/2025 and timed at 11:10 a.m., the form indicated Registered Nurse Supervisor (RNS) 1 documented in the History of Elopement Attempts section (Section F) that Resident 1 expressed he planned to leave the facility but had not attempted to do so. RNS 1 did not document in Section F that Resident 1 had made one or more elopement attempts within the past year, as Resident 1 had attempted to elope earlier that day (9/14/2025). During a review of Resident 1's Elopement and Wandering Risk Observation/Assessment form dated 9/29/2025, the Minimum Data Set Coordinator (MDSC) documented in the History of Elopement Attempts (Section F) that Resident 1 expressed he planned to leave the facility but had not attempted to do so. The MDSC did not document in Section F that Resident 1 had made one or more elopement attempts within the past year, as Resident 1 had attempted to elope on 9/14/2025.During a review of Resident 1's SBAR dated 11/02/2025 and timed at 2:25 a.m., the SBAR indicated Resident 1 was observed attempting to elope by trying to climb over a facility fence behind the east building. The SBAR indicated Resident 1 was attempting to use a bedside table (a mobile, height-adjustable C or H shaped table designed to roll under and over beds and chairs) to assist him in climbing the fence. The SBAR indicated Certified Nursing Assistant (CNA) (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 immediately intervened, redirected Resident 1 to his room, and removed the bedside tables from the area.During a review of Resident 1's Elopement and Wandering Risk Observation/Assessment form dated 11/2/2025 and timed at 8:51 a.m., the Assistant Director of Nursing (ADON) documented in the History of Elopement Attempts (Section F) that Resident 1 expressed he planned to leave the facility but had not attempted to do so. The ADON did not document in Section F that Resident 1 had made one or more elopement attempts within the past year, as Resident 1 had attempted to elope on 9/14/2025 and on 11/2/2025.During a review of Resident 1's Elopement and Wandering Risk Observation/Assessment form dated 11/17/2025, RNS 1 documented in the History of Elopement Attempts (Section F) that Resident expressed he planned to leave the facility but had no attempted to do so. RNS 1 did not document in Section F that Resident 1 had made one or more elopement attempts within the past year, as Resident 1 had attempted to elope on 9/14/2025 and on 11/2/2025.During an interview on 3/18/2026 at 12 p.m., the Director of Nursing (DON) stated Resident 1's Elopement and Wandering Risk Observation/Assessment forms were completed incorrectly. The DON stated after Resident 1's first elopement attempt on 9/14/2025, the facility staff should have accurately indicated on the Elopement and Wandering Risk Observation/Assessment forms dated 9/14/2025, 9/29/2025, 11/2/2025, 11/17/2025, and 11/21/2025 Resident 1's actual attempt to elope by jumping over a fence and indicating prior attempts. The DON stated the assessment forms documented by facility staff provided an inaccurate depiction of Resident 1's history.During a review of the facility's policy and procedure (P&P) titled Charting and Documentation, dated 1/2026, the P&P indicated documentation in the medical record will be objective (not opinionated or speculative), complete and accurate.