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	01/12/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 Based on observation, interview, and record review, the facility failed to ensure one of 2 sampled residents (Resident 136) was treated with respect and dignity by failing to provide clean clothing for Resident 136. This deficient practice violated the rights of the residents for dignity. Findings: During a review of Resident 136's admission record, the admission record indicated Resident 136 was originally admitted on [DATE] and readmitted to the facility on [DATE] with diagnoses of paranoid schizophrenia (an illness that causes fixed beliefs about something that is not based on reality, seeing or hearing things that don't exist, disorganized thinking and speech), hypertension (high blood pressure), and type 2 diabetes mellitus (impaired ability to process sugar). During a review of the Resident 136's Minimum Data Set (MDS- a comprehensive assessment and care planning tool) dated 12/26/2023, the MDS indicated Resident 136 had severe cognitive (ability to make decisions of daily living) impairment. The MDS indicated Resident 136 required partial moderate assistance (helper lifts, holds or supports trunk or limbs, but provides less than half the effort) in toilet hygiene, shower / bathing, personal hygiene, and lower body dressing. During an observation on 1/8/2023 at 10:15 a.m., Resident 136 was in her room, wearing an all-black jogging suit with multiple white stains (that could have been from food) that varied from one to 10 centimeters (cm unit of measure of length) in diameter (length of the center of a circle) on the front lower jacket and upper pant legs. During an interview on 1/ 11/2024 at 11:16 a.m. with LVN 8, LVN 8 stated if Resident 136 refuse d to be changed after approaching her multiple times a change of condition and care plan must be done to make sure there is a goal for resident 136. LVN 8 stated leaving Resident 136 with soiled clothing on could have a negative impact on her leaving Resident 136 feeling embarrassed. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/12/2024 at 08:46 a.m., with the Director of Nursing (DON), the DON stated when Resident 136 refused to have her clothing changed the nurse mist do a change of condition and must be care planed it is important to make sure the residents needs are being met. DON stated keeping the Residents clothing clean is important for their self- esteem the Resident can be a danger themselves, dirty clothing carry germs. During a review of the facility's policy and Procedure (P&P) titled, Answering the Call Light, undated, indicated, General Guidelines .5. When the resident is in bed or confined to a chair be sure the call light is within reach of the resident. During a review of the facility's policy and Procedure (P&P) titled, Quality of Life-Dignity, undated, indicated, Policy Statement: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Policy Interpretation and Implementation . 2Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to ensure 8 of 64 sampled residents (Resident 576, Resident 577, Resident 73, Resident 3, resident 74, Resident 198, Resident 150, and Resident 82): 1. were assisted in formulating their advance directives (a legal document that allows an individual to state in advance their wishes should they become unable to make healthcare decisions), and 2. had a completed acknowledgement of advance directives and Physician Orders for Life-Sustaining Treatment (POLST a medical order that helps give people with serious illness more control over their care during a medical emergency) in their medical records. These failures had the potential for delay of care and treatment and/ or inadvertently missed health care wishes/ decisions of the residents during emergency, end of life and changes in condition. Findings: A. During a review of Resident 576's Admission Record, the Admission Record indicated Resident 576 was self-responsible and was admitted to the facility on [DATE] with a diagnoses that included Parkinson's disease (a movement disorder of the nervous system that gets worse overtime), atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate) and paranoid schizophrenia (a mental illness where a person may feel distrustful and suspicious of other people and acts accordingly). During a review of Resident 576's medical record titled, Admission/ Readmission Evaluation assessment dated [DATE], the Admission/ Readmission Assessment indicated Resident 576 was with intact cognition (mental process that involves knowing, learning, and understanding things) and was alert and oriented to person, time, place, and situation. During an interview on 1/8/2023 at 10:07 a.m., with Resident 576, Resident 576 stated he was not assisted and given information by the facility on how to make health wishes/ decisions for himself. B. During a review of Resident 577 Admission Record, the Admission Record indicated Resident 577 was self-responsible and was admitted to the facility on [DATE] with diagnoses that included major depressive disorder (a condition that causes persistent feelings of sadness, low mood and sense of despair), psychosis (a condition when a person lose contact with reality) due to substance abuse brought on by alcohol or drug use, and hypertension (a condition in which the blood vessels in the body have persistently raised pressure). During a review of Resident 577's medical record titled, Admission/ Readmission Evaluation assessment dated [DATE], the Admission/ Readmission Assessment indicated Resident 577 was with intact cognition and was alert and oriented to person, time, and place. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/8/2024 at 10:07 a.m., with Resident 577, Resident 577 stated he was not assisted and given information by the facility on how to make health wishes/ decisions for himself. During an interview on 1/10/2024 at 9:40 a.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 576 and Resident 577 are newly admitted to the facility; however, they must have an advance directive in their medical record to ensure their health wishes are followed and/ or respected when their life situation changes. During an interview on 1/10/2024 at 2:00 p.m., with the Social Services Director (SSD), SSD confirmed Resident 576 and Resident 577 have no advance directives in place and stated the facility must make intentions to achieve an advance directive for all residents so the nursing staff can have a basis on what to act on during the residents' change of condition and healthcare emergencies. C. During a review of Resident 73's Admission Record, the record indicated an admitted [DATE] with diagnoses including dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities). During a review of Resident73's Minimum Data Set ([MDS]- a standardized screening and care assessment tool) dated 12/21/2023, the MDS indicated Resident 73's cognitive (thinking and reasoning) skills were severely impaired with daily decision making. During a record review of Resident 73's advance directive acknowledgement form, there was not completed acknowledgement form. D. During a review of Resident 3's Admission Record, the record indicated Resident 3 was admitted on [DATE] with the diagnoses including paranoid schizophrenia. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's cognition was moderately impaired with daily decision making. During a record review of Resident 3's advance directive acknowledgement form dated 6/23/2023, the form was missing initials next to the four statements and the witness line was empty. E. During a review of the Admission Record indicated Resident 74 was admitted to the facility on [DATE], with diagnoses that included schizophrenia, anxiety, and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity, and concentration). During a review of Resident 74's MDS, dated [DATE], the MDS indicated Resident 74 had difficulty recalling information and had moderate cognitive impairment. During a review of Resident 74's Advance Directive Acknowledgement form dated 7/3/2023, the Advance Directive Acknowledgement form was incomplete. The form was missing a second witness and the credentials and identity of the witness who obtained the information from the residents' representative. The form was also missing initials to show information had been given to the responsible party. F. During a review of the Admission Record, the Admission Record indicated Resident 198 was readmitted to the facility on [DATE], with diagnoses that included schizophrenia and personal history of traumatic brain injury (brain dysfunction caused by outside force). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the MDS dated [DATE], the MDS indicated Resident 198 had difficulty recalling information and had short-term and long-term memory problems. During a review of Resident 198's Advance Directive Acknowledgement form dated 7/3/2023, the Advance Directive Acknowledgment form was incomplete. The form was missing a second witness and the credentials and identity of the witness who obtained the information from the residents' representative. The form was also missing initials to show information had been given to the responsible party. G. During a review of Resident 150's admission record, the admission record indicated Resident 150 was admitted to the facility initially on 6/21/2019 and the last re-admission was on 9/8/2023. Resident 150's diagnoses included schizophrenia, epilepsy (a nerve disorder marked by sudden recurrent episodes of loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain), dementia, and generalized muscle weakness. During a review of Resident 150's History and Physical (H&P), dated 11/30/2023, the H&P indicated, Resident 150 did not have the capacity to understand and make medical decisions. During a review of Resident 150's MDS, dated [DATE], the MDS indicated Resident 150 required dependent assistance (helper does all the effort) from two or more staff for bed mobility, transfer, eating, personal hygiene, shower, and dressing. During a review of Resident 150's Advance Directive Acknowledgement form, dated 7/3/2023, the Advance Directive Acknowledgment form indicated, statement sections (number one to four) were left blank without initials from the responsible party. The Advance Directive Acknowledgment form indicated, verbal consent was given from responsible party on 7/3/2023 and there was no witness name or signature documented. During a concurrent interview and record review on 1/9/2024, at 10:30 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 150's POLST, dated 11/30/2023 was reviewed. The POLST indicated, section C (Artificially Administered Nutrition) was left blank. The POLST indicated, the area for the physician's signature was left blank on Section D (Information and Signature) and the witness's name was not documented for telephone consent. The POLST indicated, the preparer's name and phone number were not documented. RNS 1 stated, Resident 150's POLST was incomplete, and she would have to contact the responsible party to find out POLST information in case of an emergency. RNS 1 stated, there was no Advance Directive Acknowledgement from was in the chart. RNS 1 stated, the Advance Directive Acknowledgement form and the POLST provided guidelines for treatment during emergencies such as a code blue (a hospital code used to indicate a patient required immediate life saving measures). RNS 1 stated, incomplete Advance Directive Acknowledgement form and POLST would delay the treatment and life saving measures and should be available in the chart for immediate access. H. During a review of Resident 82's Admission Record, the Admission Record indicated Resident 82 was admitted to the facility initially on 7/21/2021 and the last re-admission was on 11/9/2023. Resident 82's diagnoses included myocardial infarction (tissue death of the heart muscle due to lack of oxygen), schizoaffective disorder (a mental illness that can affect the thoughts, mood, and behaviors), traumatic brain injury and essential hypertension (high blood pressure that is not due to another medical condition). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 82's H&P, dated 11/10/2023, the H&P indicated, Resident 82's understanding and capacity to make medical decisions fluctuated. During a review of Resident 82's MDS, dated [DATE], the MDS indicated Resident 82 required supervision assistance from one staff for eating, oral hygiene, moderate assistance (helper does less than half the effort) from one staff for personal hygiene, dressing, transfer, bed mobility, maximal assistance (helper does more than half the effort) from one staff for shower. During a review of Resident 82's Advance Directive Acknowledgement form, dated 7/3/2023, the Advance Directive Acknowledgement form indicated, statements sections (number one to four) were left blank without initials from the responsible party. The Advance Directive Acknowledgement form indicated, verbal consent was given from responsible party on 7/3/2023 and there was no witness name documented. During a concurrent interview and record review on 1/9/2024, at 10:39 a.m., with RNS 1, Resident 82's POLST, dated 11/30/2023 was reviewed. The POLST's indicated, section B (Medical Interventions), section C (Artificially Administered Nutrition), section D (Information and Signatures), physician name, and preparer's name were left blank. RNS 1 stated, the POLST was not completed. RNS 1 stated, Resident 82's POLST was not filled out and was not completed. During an interview on 1/9/2024, at 12:01 p.m., with the SSD, the SSD stated, Resident 150 and Resident 82's Advance Directive Acknowledgement form and POLST were incomplete. The SSD stated, it was important to complete the Advance Directive Acknowledgement form and POLST to let the staff know the residents' wishes for treatment during emergency situations. The SSD stated, incomplete Advance Directive Acknowledgement forms and POLSTs could delay live saving measures for the residents and could also lead to possible legal issues. During an interview on 1/11/2024, at 12:13 p.m., with the Director of Staff Development (DSD), the DSD stated she did not provide in-service (staff education) about the Advance Directive Acknowledgement form and the POLST. The DSD stated, nursing staff could initiate the Advance Directive Acknowledgement form and the POLST form, and SSD should have ensured they knew how to fill them out correctly. During an interview on 1/11/2024, at 2:46 p.m., with Director of Nursing (DON), the DON stated, every section of the Advance Directive Acknowledgement form and the POLST should be filled out signed and dated by responsible parties and witnesses to be valid. The Advance Directive Acknowledgement form and POLST should be complete as soon as possible because they provided information on the residents' wishes during emergencies. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure(P&P) titled, Advance Directives, revised 9/2022, the P&P indicated, Policy Statement: The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Policy Interpretation and Implementation: Definition . 1. a. Advance Directive- a written instruction, such as a living will or durable power of attorney for health care, recognized by state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when the individual is incapacitated .h. physician Orders for Life-Sustaining Treatment (or POLST) paradigm form - a form designed to improve patient care by creating a portable medical order form that records patients treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patients current medical condition into consideration . If the Resident Does not have an Advance Directive . 2. Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff . 7.The staff development coordinator is responsible for scheduling training regarding advance directives for newly hired staff members as well as scheduling annual advance in-services to ensure that the staff remains informed about the residents rights to formulate advance directives and facility policy governing such rights. 45537 46537 49131

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36943 Based on observation, interview, and record review, the facility failed to notify the primary physician and responsible party (RP 1) of a significant change in condition (major decline or improvement in a resident's status that will not resolve itself without intervention) for one of five sampled residents (Resident 110) with limited range of motion [ROM, full movement potential of a joint (where two bones meet)]. For Resident 110, the facility failed to: 1. Report Resident 110's sudden ROM decline in the right, dominant hand (the hand usually used during completion of daily living tasks such as eating, and brushing teeth) from within functional limits (WFL, sufficient movement without significant limitation) on 6/25/2023 to severe impairment (25% or less of full PROM) in the right hand on 7/19/2023 to nursing and Resident 110's primary physician in accordance with the care plan and facility's policy, 2. Report Resident 110's refusal to participate in ROM exercises in the right hand, Resident 110's increased complaints of pain, and the refusal to apply a right-hand splint (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) to nursing in accordance with Resident 110's care plan and facility policy, and 3. Ensure Resident 110's consulting physiatrist (MD 1, specialist physician who treats patients with injuries or suffer from disabilities that affect physical and cognitive functioning) communicated Resident 110's clinical diagnosis (diagnosis made on basis of medical signs and reported symptoms, rather than diagnostic tests) on 6/30/2023 of Dupuytren's contracture (an abnormal thickening of tissues in the palm of the hand) on the right to the primary physician and RP 1, including recommendations and treatment options. These failures resulted in Resident 110 developing severe limitations in ROM, increased pain, and decreased function of the right, dominant hand. Cross reference F688. Findings: During a review of Resident 110's Admission Record, the facility admitted Resident 110 on 5/31/2023 and readmitted on [DATE] with diagnoses including rhabdomyolysis (condition where damaged muscle tissue releases a substance into the bloodstream which can damage the kidneys), muscle weakness, adult failure to thrive (condition where an adult experiences inadequate nutrition), attention to gastrostomy (G-tube, a tube placed directly in the stomach for long-term feeding), and unspecified dementia (decline in mental ability severe enough to interfere with daily life) with agitation (feeling of anxiety or irritability). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 110's Minimum Data Set (MDS, a comprehensive assessment and care planning tool), dated 6/3/2023, the MDS indicated Resident 110 had no speech, rarely expressed ideas and wants, rarely understood verbal content, and was severely impaired for daily decision making. The MDS indicated Resident 110 required extensive assistance (resident involved in activity with staff support) with dressing and personal hygiene and dependent (full staff assistance) with eating. The MDS also indicated Resident 110 did not have any impairments in ROM to both arms and both legs. During a review of Resident 110's medical record, the record indicated a physician's order, dated 6/27/2023, for 650 milligrams (mg, a unit of measure of weight) of Tylenol (Acetaminophen, pain reliever) through the G-tube every four hours as needed for pain. During a review of Resident 110's MDS, dated [DATE], the MDS indicated Resident 110 had clear speech, usually expressed ideas and wants, usually understood verbal content, and had improved to intact cognition. The MDS indicated Resident 110 required partial/moderate assistance (helper does less than half the effort) for eating and personal hygiene. The MDS indicated Resident 110 had ROM impairments in one arm. 1. During a review of Resident 110's Occupational Therapy [OT, profession aimed to increase or maintain a person's capability of participating in everyday life activities (occupations)] Evaluation and Plan of Treatment, dated 6/27/2023 signed by Occupational Therapist 1 (OT 1), the OT Evaluation indicated Resident 110 had impaired ROM to both shoulders but had active range of motion (AROM, performance of ROM of a joint without any assistance or effort of another person) to lift both arms above shoulder height. The OT Evaluation indicated Resident 110 did not have any contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) and the ROM in both of Resident 110's elbows, forearms, wrists, and hands were within functional limits (WFL, sufficient movement without significant limitation). During a review of Resident 110's care plan, initiated 6/27/2023, the care plan indicated Resident 110 was at risk for mobility (ability to move) issues. Resident 110's care plan included an intervention, initiated on 7/7/2023, to report any further deterioration in status to the physician. During a review of Resident 110's OT Treatment Encounter Note, dated 7/6/2023 signed by Certified Occupational Therapy Assistant 1 (COTA 1), the OT Treatment Encounter Note indicated COTA 1 placed a hand towel roll (rolled-up hand towel) to Resident 110's right hand to improve contractures to the (unspecified) fingers. The OT Treatment Encounter Note indicated Resident 110 was unable to open the right hand due to the finger contractures and had difficulty with handling objects with the right hand due to tightness in the fingers. During a review of the Rehab - Joint Mobility Screen [passive range of motion (PROM, movement of joint through the ROM with no effort from the person) assessment of the joints], dated 7/21/2023 signed by the Clinical Resource Therapist (CRT), the Rehab - Joint Mobility Screen indicated Resident 110 had WFL PROM in all joints except minimal ROM impairment (approximately 75% of full ROM) in the right shoulder and severe ROM impairment (25% or less of full ROM) in the right hand. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/9/2024 at 11:20 AM in the bedroom, Resident 110 was awake, alert, and moving the left arm actively while lying in bed. Resident 110 was asked to move the right arm, but Resident 110 stated, I don't have a right arm. Resident 110's right hand was in a closed fist position with the forearm positioned in supination (turned with the palm facing upward). Resident 110 slightly lifted the right arm at the shoulder and elbow joints to bend and extend the arm. Resident 110 stated the therapists (in general) did not assist with opening the right hand but placed a splint inside the right hand every one or two days. Resident 110 stated it has been two days since a splint was placed in the right hand and felt that the hand splint was not working. Resident 110 stated, One of my reasons of being here (at the facility) was to build the body, not regress (returning to a less developed state). And I've regressed. During a concurrent interview and record review on 1/11/2024 at 11:39 AM with the Director of Rehabilitation (DOR) and OT 1, the DOR stated Resident 110 received an OT Evaluation on 6/27/2023 which indicated Resident 110 did not have any contractures and both hands had WFL ROM. The DOR reviewed Resident 110's Rehab - Joint Mobility Screen, dated 7/21/2023, which indicated Resident 110 right hand had a severe impairment. During a concurrent interview and record review on 1/11/2024 at 12:10 PM with the DOR and OT 1, the DOR and OT 1 stated it was a significant change for Resident 110 to progress from WFL in the right hand to severe ROM impairment in the right hand. The DOR and OT 1 stated Resident 110's significant change should have been but was not reported to nursing. The DOR reviewed Resident 110's clinical records and did not locate any documentation regarding any significant changes of condition documentation for Resident 110's significant ROM decline in the right-hand. During an interview on 1/12/2024 at 11:53 AM with the DON, the DON stated a significant change of condition assessment should have been completed for Resident 110's right-hand. The DON stated a change of condition assessment included an assessment of the resident, notifying the primary physician, notifying the responsible party, and revising the care plan. The DON stated Resident 110's primary physician was not aware of Resident 110's significant ROM decline in the right-hand. During a review of the facility's Policy and Procedure (P&P) titled, Change in a Resident's Condition or Status, revised 2/2021, the P&P indicated the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The P&P indicated the nurse will notify the resident's attending physician when there has been a significant change in the resident's physical/emotional/mental condition. 2. During a review of Resident 110's care plan, initiated 6/27/2023, the care plan indicated Resident 110 was at risk for mobility (ability to move) issues. Resident 110's care plan included an intervention, initiated on 7/7/2023, to monitor, report and record presence of pain or intolerance during mobility. During a review of Resident 110's OT Evaluation and Plan of Treatment, dated 9/12/2023 signed by OT 2, the OT Evaluation indicated both of Resident 110's shoulders had impaired ROM with the right arm more affected than the left. The OT Evaluation indicated Resident 110's right hand ROM was impaired, but Resident 110 did not allow any ROM to the right hand due to complaints of pain. The OT Evaluation indicated nursing was notified regarding Resident 110's pain but did not indicate whether Resident 110 received any pain medication. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 110's care plan, initiated 9/12/2023, the care plan indicated Resident 110 had a self-care deficit (problem) related to confusion, muscle weakness, impaired mobility, and right-hand contracture. Resident 110's care plan included interventions, initiated on 9/12/2023, to monitor, document, report to the physician as needed for any changes, any potential for improvement, reasons for self-care deficit, expected course, and declines in function. During a review of the OT Treatment Encounter Note, dated 9/18/2023, the OT Treatment Encounter Note indicated Resident 110 refused ROM to the right wrist and fingers due to fear of pain. The OT Treatment Encounter Note did not indicate Resident 110 received pain medication. During a review of Resident 110's OT Treatment Encounter Note, dated 9/26/2023, the OT Treatment Encounter Note indicated Resident 110 declined any movement of the right arm, had heighted irritability, and exhibited signs of guarding pain when attempting to touch or move the right arm. The OT Treatment Encounter Note did not indicate nursing was notified of Resident 110's pain and whether pain medications were administered. During a review of Resident 110's OT Treatment Encounter Note, dated 9/27/2023, the OT Treatment Encounter Note indicated Resident 110 refused any stretching of the right-hand fingers. During a review of Resident 110's OT Treatment Encounter Note, dated 10/12/2023, the OT Treatment Encounter Note indicated Resident 110 refused application of the right-hand carrot splint (splint shaped like a carrot with one side thicker than the other which positioned the fingers away from the palm to protect the skin from moisture, pressure, and nail puncture). During an observation and interview on 1/11/2024 at 12:56 AM with the DOR and OT 1 in Resident 110's bedroom, Resident 110 stated he felt pain from the right hand all the way up the right arm and stated, I just want to saw it (the right arm) off. Resident 110's right hand was positioned in a fist when OT 1 attempted to passively extend the fingers. Resident 110 moaned and stated he felt the sensation of pain in the right hand. Resident 110 was unable to extend any fingers on the right hand upon OT 1's request. OT 1 stated Resident 110's right hand was tight with severe limitations in all finger joints of the right hand. Resident 110 attempted to bend the right wrist but again moaned with pain. OT 1 stated Resident 110's right wrist ROM was severely limited due to pain. Resident 110 bent and extended the right elbow joint but only slightly lifted the right arm at the shoulder joint. OT 1 attempted to perform PROM to the right shoulder joint but stated Resident 110 could not tolerate additional movement due to pain. OT 1 stated Resident 110 used to move the right arm but now has right-hand tightness and limited movement due to pain in the right arm. During a concurrent interview and record review on 1/11/2024 at 5:44 PM, the DOR stated nursing should have been involved if Resident 110 refused treatment to the right-hand. The DOR stated the facility should have but did not perform an interdisciplinary (IDT) meeting regarding Resident 110's refusals to participate in treatment. During a concurrent interview and record review on 1/11/2024 at 6:12 PM, the DON reviewed the nursing progress notes for Resident 110 and stated there was no documentation Resident 110 refused treatment during therapy sessions. The DON reviewed Resident 110's Medication Administration Record (MAR) from 6/2023 to 1/2024 and stated Resident 110 never received any pain medication. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Change in a Resident's Condition or Status, revised 2/2021, the P&P indicated the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The P&P also indicated the nurse will notify the resident's physician of refusal of treatment or medications two (2) more more consecutive times. During a review of the facility's P&P titled, Requesting, Refusing and/or Discontinuing Care or Treatment, revised 2/2021, the P&P indicated an appropriate member of the IDT will meet with the resident/representative to determine why he or she is requesting, refusing, or discontinuing care or treatment and to try to address his or her concerns and discuss alternative options. 3. During a review of Resident 110's Physical Medicine and Rehabilitation Initial Evaluation, dated 6/30/2023, the Physical Medicine and Rehabilitation Initial Evaluation indicated Resident 110's chief complaint included muscle weakness and lack of coordination. The Initial Evaluation also indicated Resident 110 had limited ROM in both shoulders, both hips, and both ankles. During a review of Resident 110's Physical Medicine and Rehabilitation Follow-up, dated 7/11/2023, the Physical Medicine and Rehabilitation Follow-up indicated Resident 110's chief complaint included mobility and activities of daily living (ADLs, tasks related to personal care including bathing, dressing, hygiene, eating, and mobility) dysfunction due to muscle weakness and lack of coordination. During a review of Resident 110's Physical Medicine and Rehabilitation Follow-up notes, the clinical record indicated MD 1 assessed Resident 110 on each of the following dates; 7/4/2023, 7/7/2023, 7/11/2023, 7/14/2023, 7/18/2023, 7/21/2023, 7/25/2023, 7/28/2023, 8/16/2023, 8/18/2023, 8/22/2023, 8/25/2023, 8/29/2023, 9/1/2023, 9/5/2023, 9/8/2023, 9/12/2023, 9/15/2023, 9/19/2023, 9/22/2023, 9/26/2023, 9/29/2023, 10/3/2023, 10/6/2023, 10,10/2023, 10/13/2023, 10/17/2023, 10/20/2023, 10/24/2023, 10/27/2023, 10/31/2023, 11/3/2023, 11/7/2023, 11/10/2023, 11/14/2023, 11/17/2023, 11/21/2023, 11/24/2023, 11/28/2023, 12/1/2023, 12,5/2023, 12/8/2023, 12/12/2023, 12/15/2023, 12/19/2023, 12/22/2023, 12/26/2023, 12/29/2023, and 1/2/2024. During an interview on 1/12/2024 at 8:26 AM, MD 1 stated he was the consulting physiatrist for Resident 110, and came to the facility at least twice per week,. MD 1stated he has been working with Resident 110 for the past six months. MD 1 stated Resident 110 did not want MD 1 to touch him on most visits. During an observation on 1/12/2024 at 8:37 AM with MD 1 in Resident 110's bedroom, MD 1 touched and examined Resident 110's right hand. Resident 110 stated he usually did not like MD 1 touching the right-hand because of pain. During an interview on 1/12/2024 at 8:55 AM in Resident 110's bedroom with MD 1, Resident 110 stated he was right-hand dominant and initially felt numbness in the right hand. Resident 110 stated the fingertips started to bend, like a claw, and then gradually tightened up into a fist. Resident 110 stated the therapists first started putting a carrot splint in the right hand three days per week. Resident 110 stated the carrot splint did not assist with loosening his fingers, did not fit properly, and did not have a strap to secure it to the right hand. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/12/2024 at 9:03 AM with MD 1, MD 1 stated Resident 110 was clinically diagnosed with Dupuytren's contracture on the right hand. MD 1 stated Resident 110's right hand began to bend at the right ring and little fingers, but MD 1 stated Resident 110 could still use the right thumb, index, and middle fingers to eat. MD 1 stated Dupuytren's was progressive (disease or physical ailment whose course in most cases is the worsening, growth, or spread of the disease) and had three treatment options to temporarily slow down the progression. MD 1 stated the first option was surgery, the second option was injecting an enzyme (chemical) into the palm, and the third option included providing ROM and a splint to Resident 110's right hand. MD 1 stated MD 1 never discussed Resident 110's clinical diagnosis of Dupuytren's contracture with Resident 110's primary physician. MD 1 reviewed the Physical Medicine and Rehabilitation Follow-up notes. MD 1 stated he did not document Resident 110's clinical diagnosis in any of Resident 110's Physical Medicine and Rehabilitation Follow-up notes from 6/2023 to 1/2024. MD 1 stated he did not document that Resident 110's contractures started in the ring and small fingers and also did not document when Resident 110's contractures started involving the entire right-hand. MD 1 also stated he has never seen any of the splints provided to Resident 110 to manage the contractures. During an interview on 1/12/2024 at 1:44 PM via telephone with Resident 110's Responsible Party (RP 1), RP 1 stated Resident 110 was healthy prior to living at the facility. RP 1 stated Resident 110 never ever had any issues with the right hand. RP 1 told the facility staff (unknown) that Resident 110's right hand was not working and asked about treatment options, including surgery, to help improve the right hand. RP 1 stated a carrot splint was placed to the right hand but did not feel it was effective treatment for the fingers and the pain. During an interview with RP1 on 1/12/2024 at 3:32 PM, RP 1 stated no one from the facility informed RP 1 of Resident 110's Dupuytren's contracture diagnosis and the treatment options. During a review of the facility's P&P titled, Facility Consultants, revised 12/2009, the P&P indicated outside consulted provided the Administrator with written, dated, and signed reports for each consultation visit. The P&P indicated the consultation reports should include recommendations, plans for implementation of the recommendations, findings, and plans for continued assessment. The P&P indicated significant changes in the level of the resident's pain should be reported to the physician.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed provide privacy by completely closing privacy curtains during perineal care (genital and rectal care) for one of 36 sampled residents (Resident 81). This failure had the potential to violate Resident 81's rights for respect and dignity. Findings: During a review of Resident 81's Admission Record, the Admission Record indicated the facility initially admitted Resident 81 on 9/27/2022 and was readmitted on [DATE] with diagnoses including Parkinson's disease (brain disorder that causes unintended or uncontrollable movements and difficulty with balance and coordination), muscle weakness, and fecal impaction (occurs when hard mass of stool gets makes it difficult to have a bowel movement). During a review of Resident 81's Minimum Data Set (MDS, a comprehensive assessment and care planning tool), dated 12/20/2023, the MDS indicated Resident 81 had clear speech, expressed ideas and wants, understood verbal content, and had moderately impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 81 was dependent (helper does all of the effort) for toileting hygiene (ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement), upper body dressing, lower body dressing, and rolling to both sides (ability to roll from lying on back to left and right side, and return to lying on back on the bed). During a review of Resident 81's care plan for self-care performance deficit (decreased ability), initiated on 10/6/2023, the care plan interventions included to promote dignity by ensuing privacy. During an observation on 1/10/2024 at 2:31 PM in Resident 81's bedroom, Resident 81's bed was positioned perpendicularly (at an angle) to another bed, which was occupied by Resident 81's roommate who was sleeping. Certified Nursing Assistant 3 (CNA 3) went to the bathroom sink to wet a towel, which she placed into a plastic bag. CNA 3 walked from the bathroom to Resident 81's bed. The privacy curtain between Resident 81 and the sleeping roommate was not closed. Resident 81's body was turned to the left side with a fully exposed backside while CNA 3 cleaned Resident 81's perineal area. During an interview on 1/10/2024 at 2:46 PM with CNA 3, CNA 3 stated she did not pull Resident 81's privacy curtain all the way. During an interview on 1/11/2024 at 6:54 PM with the Director of Nursing (DON), the DON stated it was important for staff to ensure privacy curtains were completely pulled during perineal care to maintain dignity. During a review of the facility's Policy and Procedure (P&P) titled, Dignity, revised 2/2021, the P&P indicated each resident shall be care for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P included that Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 46537 Based on observation, interview, and record review, the facility failed to identify, appropriately assess, monitor and release physical restraint(defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body) for one of one sampled resident (Resident 150) every two hours as ordered during the use of hand mittens (soft gloves that are designed to restrict the movement of one or both hands, and are used with patients who have removed essential lines or tubes on more than one occasion.) and abdominal binder (a compression belt that encircle abdomen, commonly used to augment the recovery process) to prevent the residents from pulling out his gastrostomy tube ([G-tube]- a tube inserted through the belly that brings nutrition directly to the stomach). This failure had the potential to result in restricting movement, skin injury, and compromised circulation on hands and abdomen of Resident 150. Findings: During a record review of Resident 150's Admission Record, the admission record indicated Resident 150 was admitted to the facility initially on 6/21/2019 and last re-admission was on 9/8/2023. Resident 150's diagnosis included schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), epilepsy (a neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), generalized muscle weakness (a decrease in muscle strength) and dysphagia (difficulty swallowing). During a record review of Resident 150's History and Physical (H&P), dated 11/30/2023, the H&P indicated, Resident 150 had no capacity to understand and make medical decisions. During a record review of Resident 150's Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 1/9/2024, the MDS indicated Resident 150 required dependent assistance (helper does all the effort) from the two or more staff for bed mobility, transfer, eating, personal hygiene, shower, and dressing. During a record review of Resident 150's Order Summary Report (OSR), dated 1/10/2024, the OSR indicated, Bilateral hand mittens ordered for every eight hours as needed for preventing dislodgement of G-tube with order date of 12/8/2023. The OSR indicated, remove bilateral hand mittens every two hours as needed to assess for proper circulation and discoloration with order date of 12/8/2023. The OSR indicated, apply abdominal binder (a compression belt that encircle abdomen, commonly used to augment the recovery process) to prevent dislodgement of G-tube and release every two hours for five minutes for skin check with order date of 12/3/2023. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 150's Care Plan (CP), initiated on 11/29/2023, the CP Focus indicated, physical restraints (bilateral hand mittens and abdominal binder) was used due to reoccurring G-tube dislodgement. The CP Goal indicated, minimize and eliminate use of restraints and Resident 150 would be remain free of complications related to restraint use including contractures (,a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) skin breakdown, and withdrawal. The CP Interventions indicated, monitor, document, and report to physician as needed for changes regarding effectiveness of restraint and adverse/negative effects. During a review of Resident 150's Medication Administration Record (MAR), dated from 12/1/2023 to 1/10/2024, the MAR indicated, there was no documentation on hand mittens monitoring. The MAR indicated, remove bilateral hand mittens every two hours as needed to assess for proper circulation and discoloration and was left blank (undocumented). The MAR also did not indicate that the abdominal binder was released every 2 hours. During an observation on 1/8/2024, at 9:57 a.m., in Resident 150's room, Resident 150 was sleeping. Mittens were on both hands. During an observation on 1/10/2024, at 11:30 a.m., in Resident 150's room, Resident 150 was sleeping. Mittens were on both hands and abdominal binder was on. During an interview on 1/10/2024, at 11:39 a.m., with Certified Nurse Assistant (CNA) 5, CNA 5 stated, Resident 150 had mittens for more than a month to prevent from scratching. CNA 5 stated, he was not sure the mittens were considered as restraints because Resident 150 could move his arms. CNA 5 stated, he believed anything that restricted the movement was considered as restraints, but he was not sure about mittens. CNA 5 stated, Licensed Vocational Nurse (LVN) who assigned to Resident 150 should monitor and assess for restraints. During an interview on 1/10/2024, at 11:49 a.m., with LVN 7, LVN 7 stated, Resident 150 had mittens and abdominal binder at all times except for hygiene care time because Resident 150 actively attempted pulling out his G-tube. LVN 7 stated, abdominal binder was the restraint to prevent dislodgement then mittens were added for additional protection. LVN 7 stated, she believed abdominal binder was less restricted measure and she was not sure if mittens were necessary. LVN 7 stated, the restraints should be removed every hour, assess skin integrity, and document on MAR. LVN 7 stated, it was important to assess and monitor restraints every hour to prevent injury. During an interview on 1/11/2024, at 12:13 p.m., with Director of Staff Development (DSD), DSD stated, it would be considered as restraints, if mittens or abdominal binder were placed to restrict the resident's movement. DSD stated, nursing staff should re-evaluate and assess the needs of the restraints and use less restrictive measures. DSD stated, she was not sure if both mittens and abdominal binder were used at the same time. DSD stated, nursing staff should monitor every two hours for pain, circulation, and skin breakdown to prevent unintentional injuries related to the restraint use. During an interview on 1/11/2024, at 2:46 p.m., with Director of Nursing (DON), DON stated, anything that restricted the resident's movement would be considered as restraint and least restrictive measure should be tried first. DON stated, restraint should be monitored as frequent as ordered and documented to prevent injury. DON stated, he thought nursing staff did not document monitoring and assessment of restraints because it was ordered as needed and he would ensure it be changed to routine. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Use of Restraints, revised 4/2017, the P&P indicated, Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body . 3.Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, Geri-chairs, and lap cushions and trays that the resident cannot remove . Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, revised 2/2021, the P&P indicated be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to report to California Department of Public Health (CDPH) and one or more law enforcement entities an allegation of sexual abuse for one of one resident (Resident 60) when Resident 60 reported sexual activity with an unidentified resident on 12/5/2023. This deficient practice resulted in a delay in the CDPH's and law enforcement entities' investigation and had the potential to result in further abuse to go unreported. Findings During a review of Resident 60's admission record, the admission record indicated an admitted [DATE] with the diagnosis of schizoaffective disorder (a mental health disorder in which people interpret reality abnormally and manifest intense shifts in mood and energy). During a review of Resident 60's Minimum Data Set ([MDS]- a standardized assessment and care screening tool) dated 12/14/2023, the MDS indicated Resident 60's cognition (thinking and reasoning) skills were intact. The MDS indicated Resident 60 required supervision to moderate assistance with activities of daily living (ADL, eating, drinking, transferring, and dressing). During a concurrent interview and record review on 1/12/2024 at 2:54 p.m. with the Administrator (ADM), Resident 60's Interdisciplinary (IDT) note dated 12/5/2023 was reviewed. The note indicated Resident 60 reported to a charge nurse (unidentified) she was sexually active in the unit with an unidentified resident. The IDT note indicated laboratory work was ordered to assess resident's health. The note indicated resident was assessed for possible emotional and physical distress. The note did not indicate a report was filed with the CDPH or law enforcement entities. The ADM stated the facility must report any allegations of abuse (including physical, verbal, neglect, mental, and sexual). The ADM stated an allegation was defined as an accusation which has not been investigated or determined to be true or false. The ADM stated Resident 60's report of sexual activity with an unidentified person on 12/5/2023 was not reported to CDPH or local law enforcement entities. During a review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 4/2021, the policy indicated the facility should identify all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. The policy indicated the facility should report any allegations within timeframes required by federal requirements. During a review of the facility's policy and procedure titled, Abuse Prevention, effective 12/31/2015, the Policy indicated: (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. All mandated reporters are required by law to report incidents of known or suspected abuse in two ways: 1) by telephone immediately or as soon as practically possible, to the local ombudsman and the local law enforcement agency and 2) by written report, Department of Social Services Form {SOC Form 341), Report of Suspected Dependent Adult/Elder Abuse sent within two (2) working days. Based on the Affordable Care Act, section 6703(b)(3) > If the events that cause the reasonable suspicion result in serious bodily injury, the report must be made immediately after forming the suspicion (but not later than two hours after forming the suspicion. Otherwise, the report must be made not later than 24 hours after forming the suspicion. b. The Administrator shall report all alleged or suspected violations to the appropriate state agencies and Vice-President of Operations immediately or within 24 hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to implement its abuse policy and procedure by failing to thoroughly investigate an allegation of sexual abuse for one of one resident (Resident 60) when Resident 60 reported sexual activity with an unidentified resident on 12/5/2023. This deficient practice had the potential to result in unidentified abuse in the facility and failure to protect residents from further abuse. Findings: During a review of Resident 60's admission record, the admission record indicated an admitted [DATE] with the diagnosis of schizoaffective disorder (a mental health disorder in which people interpret reality abnormally and manifest intense shifts in mood and energy). During a review of Resident 60's Minimum Data Set ([MDS]- a standardized assessment and care screening tool) dated 12/14/2023, the MDS indicated Resident 60's cognition (thinking and reasoning) skills were intact. The MDS indicated Resident 60 required supervision to moderate assistance with activities of daily living (ADL, eating, drinking, transferring, and dressing). During a concurrent interview and record review on 1/12/2024 at 2:54 p.m. with the Administrator (ADM), Resident 60's Interdisciplinary (IDT) note dated 12/5/2023 was reviewed. The note indicated Resident 60 reported to a charge nurse (unidentified) she was sexually active in the unit with an unidentified resident. The IDT note indicated laboratory work was ordered to assess resident's health. The note indicated resident was assessed for possible emotional and physical distress. The note did not indicate a report was filed with the California Department of Public Health or law enforcement entities. The ADM stated after Resident 60's reported sexual activity with an unidentified resident, nursing staff was interviewed. The ADM stated there was no documented evidence of staff interviews. The ADM stated no other residents were assessed or interviewed regarding the incident. The ADM stated the facility did not know how to find out who the other resident was. During a review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 4/2021, the policy indicated the facility should identify all possible incidents of abuse. During a review of the facility's policy and procedure titled, Abuse Prevention, effective 12/31/2015, the Policy indicated: a. The investigation and all alleged violations shall be recorded on an incident report. b. The Administrator shall initiate an investigation immediately, which may include interviews of the involved resident(s), and other parties (employees, visitors, other residents, volunteers, family members, etc.) who have knowledge of the alleged incident. These statements should be in writing and signed by the person making the statement. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. The Center's Administrator or designee shall review resident(s) medical record and any other related medical information. d. The Administrator or designee shall make a reasonable attempt to reach a conclusion as to the cause of the injury and take corrective actions during the duration of the investigation to provide resident(s) with a safe environment. e. The Administrator will initiate an investigation file labeled as Confidential. All interviews, reports, notes and other pertinent documents shall be maintained in this file. This should include an Administrator's statement concerning the incident and his/her conclusion. f. Administrator or designee shall investigate all suspected or alleged abuse and report incident to the local ombudsman or the local law enforcement agency by telephone immediately or as soon as practically possible and by written report (SOC 341) sent within two (2) working days. g. The Administrator or designee shall report the results of investigations of incidents of alleged abuse or suspected abuse in accordance with state law within five (5) working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. h. Evidence of the investigation of alleged violations shall be maintained as required by state and federal laws. The Facility investigation Report shall be completed after the investigation is complete and provided to survey agencies when requested or required by state or federal law. This form shall be maintained in the Administrator's office as part of the confidential file for Quality and Assurance review and not part of the medical record.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 46036 Based on observation, interview, and record review, the facility failed to follow through with the Preadmission Screening and Resident Review ([PASARR]- a tool to ensure possible individuals with mental illnesses or intellectual disabilities are appropriately placed in nursing homes for long term care) recommendation to obtain a PASARR Level II (helps determine placement and specialized services) evaluation for three of three sampled residents (Resident, 22 Resident 73 and Resident 74). This failure had the potential to result in inappropriate placement and unidentified specialized services for Resident 22, Resident 73, and Resident 74. Findings: A. During a record review of the Admission Record, it indicated Resident 74 was admitted to the facility on [DATE], with diagnoses that included schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), anxiety, bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity, and concentration). During a record review of the MDS ([MDS]- a standardized screening and care assessment tool) dated 12/7/2023, the MDS indicated Resident 74 had difficulty recalling information and had moderate cognitive (ability to reason, understand, remember, judge, and learn) impairment. During a record review of the Care Plan ([CP]- a form that summarizes a resident's health conditions, care needs and current treatment) dated 11/17/2023, the CP indicated Resident 74 has impaired cognitive function or impaired thought processes related to difficulty in making decisions, psychotropic drug (medication used to treat mental disorders) use, bipolar disorder, and schizophrenia. The interventions include monitoring, documenting, and reporting change in cognitive function to the medical doctor. During a record review of Resident 74's PASARR Level I completed on 11/15/2023, the PASARR Level I indicated the need for a PASARR Level II evaluation. During an interview on 1/11/2024 at 03:10 PM, the SSD1 stated Resident 74 had a positive PASARR Level I that was done at a general acute care hospital (GACH) and a copy of the PASARR Level II screening was most likely sent to the GACH. Furthermore, SSD1 states there was no follow up with the GACH for a copy and Resident 74 has not been referred for a Level II screening since admitted to the facility. B. During a record review of Resident 73's letter from PASARR office dated 9/7/2023, the letter indicated Resident 73 was positive for suspected mental illness and Resident 73 required a Level II mental health evaluation referral. During a record review of Resident 73's medical records, the medical records indicated no completed PASARR Level II was completed for Resident 73. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 73's Admission Record, the record indicated an admitted [DATE] with the diagnosis including dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities). During a record review of Resident 73's MDS dated [DATE], the MDS indicated Resident 73's cognitive (thinking and reasoning) skills was severely impaired with daily decision making. During a record review of the facility's policy and procedure dated March 2019, titled Admission Criteria, it indicated if the resident's Level I screen is positive, the resident will be referred to the state PASARR representative for the Level II screening process. During an interview on 1/11/2024 at 09:55 AM, the Social Services Director (SSD1) stated a PASSAR Level II is important because it provides special recommendations and let the facility know if the resident requires specialized services. c) During a review of Resident 22' Admission Record (AR), the AR indicated Resident 22 was originally admitted on [DATE], and readmitted on [DATE] with diagnoses including Type 2 diabetes mellitus (irregular blood sugar), schizophrenia (a mental illness characterized by hearing and seeing things that are not there), and anxiety disorder (a mental health condition characterized by symptoms of intense anxiety or panic). During a review of Resident 22's History and Physical (H/P), the H/P indicated Resident 22 had fluctuating capacity to make decisions. During a review of Resident 22' Minimum Data Set (MDS), a comprehensive assessment and screening tool, dated 11/16/2023, the MDS indicated Resident 22's cognitive skills (relating to the process of acquiring knowledge and understanding) for daily decision making were intact. During a concurrent interview and record review on 1/10/2024 at 4:22 p.m., with Social Service Director 1 (SSD 1), SSD 1 stated, Resident 22 was admitted on [DATE] but, Resident 22's PASSAR. Level I Evaluation submitted on 1/08/2024 and resulted as positive. SSD 1 stated usually the facility should be responsible for conducting PASSAR Level I screening at the time of admission. SSD 1 stated, the facility just submitted the PASSAR Level I and is currently waiting for a level II evaluation. The SSD stated, PASRR Level I should have been done earlier, at the time of admission. During an interview on 1/11/2024 at 10:06 a.m., with SSD 1, the SSD stated the admitting nurse informed the Social Services Department to follow up with the PASSAR evaluation to complete when a resident has any mental illness. The SSD stated, PASSAR screening is necessary and needs to be completed timely manner because it provides specific recommendations needed for specialized care and for making referrals to designated department as needed when staff delivers care to residents with MD. During a review of the facility's policy and procedure (P/P) titled, Admission Criteria, revised 03/2019, the P/P indicated the following: 9.a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for MD, ID, or RD. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for Level II (evaluation and determination) screening process. c. Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate. 49131

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46036 Based on observation, interview, and record review, the facility failed to develop and implement resident-centered care plan for two of eight sampled residents, (Resident 97, Resident 136) by not addressing: a. Resident 97 who had dermatitis (skin rash) on both antecubital (shaped hollow depression between the forearms) areas with a care plan for the dermatitis. b. Resident 136 's refusal to change her clothes and Resident 136 remaining dressed in soiled clothing, with a care plan for refusing to change her clothes. These deficient practices placed Resident 97 and 136 at risk of not having planned goals and interventions to meet their needs and had the potential to negatively affect the residents' physical and psychosocial well-being. Findings: a. During a review of Resident 97's Admission Record the Admission Record indicated Resident 97 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizoaffective disorder (mental health condition characterized by symptoms of delusions and disorganized thinking), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), and hyperlipidemia (elevated level of unhealthy fats in the blood). During a review of Resident 97's MDS, dated on 12/28/2023, the MDS indicated Resident 97's cognitive skills for daily decision making were intact. During a review of Resident 97's Change of Condition (COC a document with vital medical information of changes from the resident's normal state of being), dated 12/14/2023, the COC indicated Resident 97 was noted with right arm and left arm antecubital red skin rashes. The COC indicated it was reported to the Dermatologist (physician specializing in skin disorders). The COC indicated the dermatologist gave orders for treatment. During a review of Resident 97's Order Summary Report, dated 12/14/2023, the report indicated the resident had a physician's order for Triamcinolone Acetonide External Cream 0.1% (topical medication which is used to treat a variety of skin conditions), apply to right and left arm antecubital area red rashes for 10 days. During a concurrent observation and interview on 1/08/2024 at 10:30 a.m., with Resident 97, Resident 97 was observed sitting up in a wheelchair and pointing to his bilateral antecubital area which looked cracked, dry, red, and swollen. Resident 97 stated, he felt itchiness and a burning sensation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with LVN 6, and record review of Resident 97's medical records on 1/09/2024 at 11:10 a.m., LVN 6 stated there is no care plan for the resident's dermatitis on both antecubital areas. LVN 6 stated care plans are supposed to be developed for any changes of condition as soon as a nurse identifies any change of condition. b. During a review of Resident 136's admission record, the admission record indicated Resident 136 was originally admitted on [DATE] and readmitted to the facility on [DATE] with diagnoses of paranoid schizophrenia (involves fixed beliefs about something that is not based on reality, seeing or hearing things that don't exist, disorganized thinking and speech), hypertension (when force of blood going through the blood steam is consistently high), and type 2 diabetes mellitus (impaired ability of the body to processes sugar). During a review of the Resident 136's Minimum Data Set (MDS- a comprehensive assessment and care planning tool) dated 12/26/2023, the MDS indicated Resident 136 had severe cognitive impairment (having hard time remembering things , making decisions, concentrating, or learning). The MDS indicated Resident 136 required partial moderate assistance (helper lifts, holds or supports trunk or limbs, but provides less than half the effort) with toilet hygiene, shower / bathing, personal hygiene, and lower body dressing. During an observation on 1/8/2024 at 10:15 a.m. Resident 136 was in her room on her bed. Resident 136 was wearing an all-black jogging suit with multiple stains that were white in different sizes measuring 1 centimeter (cm a metric unit of length) on the front lower jacket, 5 cm on the bilateral upper pant legs, and some that were 10 cm on her bilateral lower pant legs. During an interview on 1/8/2024 at 3:39 p.m. with Licensed Vocational Nurse (LVN) 9, LVN 9 stated Resident 136's jogging suit was dirty. LVN 9 stated Certified Nurse Assistant 6, (CNA) 6 should have changed Resident 136's clothing. LVN 9 stated Resident's outfit does not look good. During an interview on 1/9/2024 at 12:05 p.m. with CNA 6, CNA 6 stated Resident 136 did not want her clothing changed CNA stated she refused many times. During an interview on 1/ 11/2024 at 11:16 a.m. with LVN 8, LVN 8 stated if Resident 136 refused to have her clothing changed after approaching multiple attempts a care plan must be started with interventions. During an interview on 1/12/2024 at 08:46 a.m., with the Director of Nursing (DON), the DON stated when Resident 136 refused to have her clothing changed the nurse must complete notify the doctor, complete a change of condition and care plan it. During an interview on 1/12/2024 at 10:18 a.m., with the DON, the DON stated resident's care plan is essential and is done upon admission, after an interdisciplinary team meeting (IDT resident's health care team involving various healthcare specialties) meeting and revised whenever there are changes in the resident's condition. The DON stated a care plan is an important tool to reflect current resident's conditions and a way for the resident's care team to communicate and implement the resident's goals and plan to achieve them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P/P) titled, Care Plans, Comprehensive Person-Centered, revised 03/2022, the P/P indicated the interdisciplinary team should review and updates the care plan: a. When there has been a significant change in the resident's condition. During a review of the facility's P/P titled, Care Planning - Interdisciplinary Team, (Revised March 2022), the P&P indicated: 1. Resident care plans are developed according to the time frames and criteria established by 483.21. 2. Compressive, person- centered care plans are based on residents' assessments and developed by an interdisciplinary team (IDT) 3. The IDT includes but not limited to; a Registered Nurse and or an LVN with responsibility for the resident. 45777

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on observation, interviews and record review, the facility failed to ensure one of 64 sampled residents (Resident 75) was consistently assisted and provided activities based on his care plan interventions. This failure has the potential to negatively affect Resident 75's psychosocial and well-being. Findings: During a review of Resident 75's Admission Record , the Admission Record indicated Resident 75 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebral infarction (a condition also known as stroke that occurs when the blood supply to the brain was interrupted or blocked causing damage to the tissues of the brain) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and eventually the ability to carry out the simplest tasks). During a review of Resident 75's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 1/5/2024, the MDS indicated Resident 75, was unable to make decisions regarding tasks for himself, had no difficulty in hearing and was totally dependent to two-person assist to complete his activities of daily living (ADLs) such as bed-to-chair and vice versa transfer, toileting and personal hygiene. During a review of Resident 75's medical record titled, Order Summary Report dated 11/13/2023, the order indicated Resident 75 may participate in activities as tolerated if not in conflict with his treatment plan. During a review of Resident 75's medical record titled, Activity assessment dated [DATE], the Activity Assessment indicated Resident 75's activity interests included music and Resident 75 would be provided a program of activities with verbal and visual cues as needed to increase his participation in the activity room and anywhere in the facility. During a review of Resident 75's medical record care plan titled, Resident is dependent on staff for activities, cognitive stimulation and social interaction dated 1/9/2024, the care plan indicated interventions that included for the staff to provide Resident 75 with one-to-one room visits and activities if not attending out of the room events twice a day by reading the daily chronicle to Resident 75 with verbal and visual cues as needed to increase Resident 75's participation. During a review of Resident 75's medical record titled, Self-directed/ Independent Activities dated 12/28/2023 to 1/9/2024, the Self-directed/Independent Activities indicated Resident 75 was seen by the activity staff once daily for 6 days over a period of 9 calendar days. During an observation on 1/8/2024 at 10:52 a.m., with Resident 75, Resident 75 was in his room napping and there was a radio (not playing) on the wall on the right side of his bed and no other activities ongoing for Resident 75. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/8/2024 at 11:00 a.m., with Responsible Party 1 (RP 1), RP 1 stated she is happy with Resident 75's care; however, she is concerned that she does not see many activities, which include things Resident 75 can feel and is able to hear being provided by the staff to Resident 75. During an observation and interaction on 1/9/20204, with Resident 75, the following were observed as follows: 1. At 10:17 a.m., there was no activity personnel in the room, the radio was not playing by his bedside and Resident 75 was awake in bed, able to track the surveyor by moving his head from side to side and he was able to follow instructions such as blinking his eyes and touching the right side of his face with his right hand. 2. At 10:33 a.m., there was no activity personnel in the room, the radio was off by his bedside, and Resident 75 was awake in bed. 3. At 11:00 a.m., there was no activity personnel in the room of Resident 75 and there was no music heard by his bedside. 4. At 12:04 p.m., Resident 75 was asleep in bed; however, opened and blinked his eyes when greeted and there was no music played (radio off) by his bedside nor an activity personnel in his room. 5. At 1:00 p.m., Resident 75 was asleep in bed and there were no activity personnel in his room nor there was music played by his bedside. 6. At 2:00 p.m., Resident 75 was able to open his eyes when his name was called; however, there was no music played by his bedside and there were no activity personnel in his room. During an observation and interaction on 1/10/2024 at 8:30 a.m., Resident 75 was able to open his eyes when greeted and when his name was called; however, there was no music playing by his bedside and there was no activity staff in his room. During an observation and interview on 1/10/2024 at 9:00 a.m., with Certified Nursing Assistant 1, CNA 1 talked to Resident 75 and Resident 75, though unable to speak, listened to CNA 1 and he had a faint smile on his face. CNA 1 confirmed Resident 75's radio was not playing and stated that usually the activity personnel would come and play his radio and read the morning paper to him in his room. CNA 1 stated Resident 75 always stays in his room, and he needed activities for brain stimulation. During an interview on 1/10/2024 at 9:07 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 75 interacts with staff by blinking his eyes and Resident 75 need activities for brain stimulation to prevent decline and ensure quality life. During an interview and record review on 1/10/2023 at 9:58 a.m. with Activity Assistant 1 (AA 1), AA 1 stated she read the morning paper to Resident 75 and played the radio (music) when she visits Resident 75 in his room. AA 1 confirmed Resident 75's plan of care for Activities was room visits twice a day and Resident 75 was only seen by the activity staff once daily in a period of 6 days over a period of 9 calendar days. AA 1 stated the activities provided contact with reality and interaction with people for Resident 75. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/10/2024 at 10:15 a.m., with the Activity Director (AD), the AD stated the residents' activity plan of care must be followed and all staff must coordinate the residents' activities to be able to participate in mental activities and social interaction. During an interview on 1/10/2023 at 10:37 a.m., with the Director of Nursing Services (DON), the DON stated all residents must be treated equally, should be provided with sensory stimulation, and opportunities to interact with others. During a review of the facility's Policy and Procedure (P/P) titled, Activity Programs revised 8/ 2006, the P/P indicated the facility's activity programs are designed to meet the needs of each resident to encourage maximum individual participation. The P/P indicated the individualized activities should reflect the resident's choices and their rights as well as their culture and other interests.

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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 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to ensure the resident, who had no impairments in the right hand and arm range of motion ([ROM], full movement potential of a joint [where two bones meet]) did not acquire an avoidable decline (reduction) in ROM and did not developed a contracture of the right hand including fingers for one of five sampled residents (Resident 110). The facility failed to: 1. Consistently apply a splint (a device used to restrict, protect, or immobilize a part of the body to support function and increase ROM) to Resident 110's right hand from 9/12/2023 to 12/5/2023, for a total of three months. 2. Ensure Resident 110 used the dominant (the hand usually used during completion of tasks of daily living such as eating, and brushing teeth) right hand for self-feeding (instead of the left hand) with built-up utensils (specialized utensils with larger handles to improve grasp) beginning 9/12/2023 to maintain ROM on the right arm and hand. 3. Ensure Resident 110 received Tylenol (Acetaminophen, pain reliever) 650 milligrams ([mg], a unit of weight measurement) for pain prior to the Occupational Therapy (OT, profession aimed to increase or maintain a person's capability of participating in everyday life activities (occupations)]Evaluation on 9/12/2023 and prior to OT Treatments of the right-hand from 9/2023 to 11/2023. 4. Ensure Resident 110's right hand ROM was assessed during the OT's Evaluation and Plan of Treatment assessment on 9/12/2023. 5. Ensure the facility's Policy and Procedure (P&P) titled, Resident Mobility and Range of Motion, was followed by having interventions including therapies, provision of necessary equipment, and/or exercises to prevent resident 110's decline in ROM and the development of right-hand contracture. These failures resulted in Resident 110 developing pain, stiffness, and decreased ROM throughout the right, dominant arm, preventing Resident 110 from using the right hand for activities of daily living ([ADLs], tasks related to personal care including bathing, dressing, hygiene, eating, and mobility), contributing to Resident 110's feelings of hopelessness and preventing Resident 110 from living at his highest practicable wellbeing. (Cross reference F580) Findings: (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 110's Admission Record, the Admission Record indicated Resident 110 was admitted to the facility on [DATE] with diagnoses including rhabdomyolysis (a condition where damaged muscle tissue releases a substance into the bloodstream which can damage the kidneys), muscle weakness, adult failure to thrive (condition where an adult experiences inadequate nutrition), unspecified dementia (a decline in mental ability severe enough to interfere with daily life) with agitation (feeling of anxiety or irritability) and with gastrostomy ([G-tube], a soft tube surgically inserted directly in the stomach for administration of nutrition and medication) tube in place. During a review of Resident 110's Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 6/3/2023, the MDS indicated Resident 110 had no speech, rarely expressed ideas, and wants, rarely understood verbal content, and had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 110 required extensive assistance (resident involved in activity with staff support) from staff with dressing and personal hygiene and total dependent (full staff assistance) with eating. The MDS also indicated Resident 110 did not have any impairments in ROM to both arms and both legs. During a review of Resident 110's OT Evaluation and Plan of Treatment, dated 6/1/2023 signed by Occupational Therapist 2 (OT 2), the OT Evaluation indicated Resident 110 had sufficient movement in ROM without significant limitation (WFL) in both arms and did not have any contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) in either arm. The OT Evaluation indicated Resident 110 was totally dependent (required more than 75 percent [%] physical assistance to perform the task) for hygiene, grooming, and upper body dressing. The OT Plan of Treatment included therapeutic exercises (movement prescribed to correct impairments and restore muscle function), neuromuscular (relating to the nerves and muscles) reeducation (a technique used to restore movement patterns through repetitive motion to retrain the brain), therapeutic activities (tasks that improve the ability to perform activities of daily living [ADL's] and self-care management training five times per week for four weeks. During a review of Resident 110's Change of Condition ([COC], documentation regarding important medical information due to a change from normal state of being) Evaluation, signed on 6/23/2023, the COC Evaluation indicated Resident 110 had a dislodged (forced out of position) G-tube on 6/15/2023. The COC Evaluation indicated Resident 110's primary physician was notified and ordered to transfer Resident 110 to the hospital for G-tube reinsertion. During a review of Resident 110's OT's Discharge Summary, dated 6/22/2023, the OT's Discharge Summary indicated Resident 110 was discharged to the hospital. During a review of Resident 110's Admission Record, the Admission Record indicated the facility readmitted Resident 110 on 6/26/2023. During a review of Resident 110's medical record, the record indicated a physician's order, dated 6/27/2023, for 650 milligrams ([mg], a unit of weight measure ment) of Tylenol (Acetaminophen, pain reliever) through the G-tube every four hours as needed for pain. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 110's Occupational Therapy (OT) Evaluation and Plan of Treatment, dated 6/27/2023 (after readmission) signed by Occupational Therapist (OT 1), the OT Evaluation and Plan of Treatment indicated Resident 110 had impaired ROM to both shoulders but had active range of motion ([AROM], performance of ROM of a joint without any assistance or effort of another person) to lift both arms above shoulder height. The OT Evaluation indicated Resident 110 did not have any contractures and the ROM in both of Resident 110's elbows, forearms, wrists, and hands were WFL. The OT Evaluation indicated Resident 110's ability to self-feed was not assessed due to the presence of a G-tube and required maximal assistance (required 50 to 75% physical assistance to perform the task) with two persons for hygiene, grooming, and upper body dressing. The OT Evaluation included a goal for Resident 110 to perform hygiene and grooming tasking with maximal assistance at the edge of bed. The OT Plan of Treatment included therapeutic exercises, neuromuscular reeducation, therapeutic activities, and self-care management training five times per week for four weeks. During a review of Resident 110's OT Treatment Encounter Note, dated 7/6/2023 signed by Certified Occupational Therapy Assistant 1 (COTA 1), the OT Treatment Encounter Note indicated COTA 1 placed a hand towel roll (rolled up hand towel) to Resident 110's right hand to improve contractures to the (unspecified) fingers. The Treatment Encounter Note indicated Resident 110 was unable to open the right hand due to finger contractures and had difficulty with handling objects with the right hand due to tightness in the fingers. During a review of Resident 110's OT Progress Report, dated 7/10/2023 signed by OT 1, the OT Progress Report indicated Resident 110 was treated for five days during the 7/4/2023 to 7/10/2023 progress period. The OT Progress Report did not indicate Resident 110 had a decline in right hand ROM. During a review of Resident 110's OT Treatment Encounter Note, dated 7/11/2023 signed by COTA 1, the OT Treatment Encounter Note indicated Resident 110 had a right-hand contracture which affected Resident 110's ability to perform hygiene and grooming. The OT Treatment Encounter Note indicated COTA 1 educated Resident 110 in (unspecified) compensatory techniques (learning a new or different way to complete a task) to perform hygiene and grooming. During a review of Resident 110's OT Progress Report, dated 7/17/2023 signed by OT 1, the OT Progress Report indicated Resident 110 was treated for five days during the 7/11/2023 to 7/17/2023 progress period. The OT Progress Report did not indicate Resident 110 had a decline in right hand ROM. The OT Progress Report included a new OT goal for Resident 110 to perform self-feeding tasks with supervision (required verbal cues but no physical assistance to perform task) using built-up utensils. During a review of Resident 110's OT Treatment Encounter Note, dated 7/20/2023 signed by COTA 1, the OT Treatment Encounter Note indicated Resident 110 had finger contractures in the right hand which required stretching and a rolled hand towel to increase finger ROM. During a review of the Rehabilitation - Joint Mobility Screening (passive range of motion [{PROM}, movement of joint through the ROM with no effort from the person] assessment of the joints), dated 7/21/2023 signed by the Clinical Resource Therapist (CRT), the Rehabilitation-Joint Mobility Screening indicated Resident 110 had WFL PROM in all joints except minimal ROM impairment (approximately 75% of full ROM) in the right shoulder and severe ROM impairment (25% or less of full ROM) in the right hand. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 110's OT Treatment Encounter Note, dated 7/21/2023 signed by Occupational Therapist 2 (OT 2), the OT Treatment Encounter Note indicated OT 2 placed a hand towel in Resident 110's right hand due to tightness and difficulty extending fingers. During a review of Resident 110's OT Recertification Progress Report, and Updated Treatment Plan (OT Recertification, assessment to justify a person's continued need to receive services), dated 7/25/2023 signed by OT 1, the OT Recertification indicated a continued OT goal for Resident 110 to perform self-feeding tasks with supervision using built-up utensils. During a review of Resident 110's OT Treatment Encounter Note, dated 7/25/2023 signed by OT 1, the OT Treatment Encounter Note indicated Resident 110 had an increased muscle tightness in the right hand. The OT Treatment Encounter Note indicated OT 1 verbally communicated Resident 110's about increased muscle tightness and need for a right-hand splint to the Assistant Director of Rehabilitation (ADOR). During a review of Resident 110's OT Treatment Encounter Note, dated 7/27/2023 signed by OT 1, the OT Treatment Encounter Note indicated OT 1 spoke with the prosthetist (professional who customizes medical devices) in person regarding Resident 110's need for a right-hand splint. During a review of Resident 110's OT Treatment Encounter Note, dated 8/1/2023 signed by COTA 2, the OT Treatment Encounter Note indicated Resident 110 received a carrot splint (device shaped like a carrot with one side thicker than the other to position the fingers away from the palm to protect the skin from moisture, pressure, and nail puncture) for the right-hand. During a review of Resident 110's OT Therapy Progress Report, dated 8/7/2023 signed by OT 1, the OT Therapy Progress Report indicated Resident 110 was seen for five days during the 8/1/2023 to 8/7/2023 progress period. The OT Progress Report indicated Resident 110 demonstrated good tolerance to the hand roll splint on the right hand and included a new OT goal to wear a hand roll on the right hand for up to four hours. During a review of Resident 110's OT Recertification, dated 8/22/2023 signed by OT 1, the OT Recertification indicated continued OT goals for Resident 110 to wear a hand roll on the right hand for up to four hours and to perform self-feeding tasks with supervision using built-up utensils. During a review of Resident 110's MDS, dated [DATE], the MDS indicated Resident 110 had clear speech, usually expressed ideas, and wants, usually understood verbal content, and had severely impaired cognitive (ability to think, understand, learn, and remember) skills for daily decision making. The MDS indicated Resident 110 required extensive assistance for eating and personal hygiene. The MDS indicated Resident 110 had ROM impairments in one arm and no impairments to both legs. During a review of Resident 110's OT Treatment Encounter Note, dated 9/8/2023, the Encounter Note indicated Resident 110 tolerated the carrot splint to the right hand for two-and-a-half hours. During a review of Resident 110's OT Discharge Summary, dated 9/11/2023, the OT Discharge Summary indicated Resident 110 required minimal assistance for self-feeding using built-up utensils and tolerated a right-hand splint for two hours. Resident 110's OT Discharge Summary did not include ROM assessments of both arms. The OT Discharge Summary indicated the reason for Resident 110's discharge from OT was a change in payor source. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of the OT Evaluation and Plan of Treatment, dated 9/12/2023 signed by OT 2, the OT Evaluation indicated both of Resident 110's shoulders had impaired ROM with the right arm more affected than the left. The OT Evaluation indicated Resident 110's right hand ROM was impaired, but Resident 110 did not allow any movement to the right hand due to complaints of pain. The OT Evaluation indicated nursing was notified regarding Resident 110's pain but did not indicate whether Resident 110 received any pain medication. The OT Evaluation indicated Resident 110 required minimal assistance for self-feeding, and a new OT Goal included for Resident 110 to perform self-feeding with supervision. The OT Evaluation did not include for Resident 110 to use built-up utensils for self-feeding and did not include the use of a right-hand splint. The OT Plan of Treatment for Resident 110 included therapeutic exercises, neuromuscular reeducation, therapeutic activities, and self-care management training four times per week for four weeks. During a review of Resident 110's Medication Administration Records (MARs) from 6/2023 to 11/2023, the MAR indicated Tylenol (Acetaminophen) was not administered. During a review of Resident 110's physician's orders, the physician's orders indicated an order, dated 10/11/2023, for a Regular diet, pureed texture (pudding like consistency that does not require chewing) with thin liquids consistency. Provide extra three to four ounces ([oz] unit of weight) of fluids with meals. During a review of Resident 110's OT Treatment Encounter Notes, dated 9/12/2023, 9/13/2023, 9/16/2023, and 9/18/2023, the OT Treatment Encounter Notes did not include the application of a right-hand carrot splint. During a review of the OT Treatment Encounter Note, dated 9/18/2023, the OT Treatment Encounter Note indicated Resident 110 refused ROM to the right wrist and fingers due to fear of pain. The OT Treatment Encounter Note did not indicate Resident 110 received pain medication. During a review of Resident 110's OT Treatment Encounter Note, dated 9/19/2023, the OT Encounter note indicated Resident 110 was protective and guarding (cautious with resistance, protecting against pain) the right hand throughout the treatment session. The OT Encounter Note indicated the right index fingernail was digging into the palm near the thumb, requiring nail clipping. The OT Encounter Note indicated Resident 110 was encouraged to use the left (non-dominant) hand for hygiene to clean the right hand using a wipe and had a carrot splint applied to the right hand for two-and-a-half hours. The OT Treatment Encounter Note did not indicate Resident 110 received pain medication. During a review of Resident 110's OT Treatment Encounter Notes, dated 9/20/2023, 9/21/2023, 9/22/2023, 9/26/2023, 9/27/2023, 9/29/2023, 10/3/2023, 10/4/2023, 10/5/2023, 10/9/2023, and 10/10/2023, the OT Encounter Notes did not include the application of a right-hand carrot splint. During a review of Resident 110's OT Recertification, dated 10/10/2023, the OT Recertification indicated Resident 110 continued to require minimal assistance for self-feeding. Resident 110's OT Recertification included an OT goal for Resident 110 to perform self-feeding with contact guard assistance (required steadying assistance to complete task). The OT Recertification did not include for Resident 110 to use built-up utensils for self-feeding and did not include the use of a right-hand splint. The OT Plan of Treatment for Resident 110 included therapeutic exercises, neuromuscular reeducation, therapeutic activities, and self-care management training four times per week for four weeks. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 110's OT Treatment Encounter Note, dated 10/11/2023, the OT Treatment Encounter Note did not include the application of a right-hand carrot splint. During a review of Resident 110's OT Treatment Encounter Note, dated 10/12/2023, the OT Treatment Encounter note indicated Resident 110 refused the right-hand carrot splint. During a review of Resident 110's OT Treatment Encounter Notes, dated 10/16/2023, 10/17/2023, 10/18/2023, and 10/19/2023, the OT Treatment Encounter Notes did not include the application of a right-hand carrot splint. During a review of Resident 110's OT Treatment Encounter Note, dated 10/20/2023, the OT Treatment Encounter Note indicated Resident 110 heavily guarded the right arm but allowed the application of the right-hand carrot splint with a gentle approach and redirection. The OT Encounter Note did not indicate Resident 110 received any pain medication. The OT Encounter Note indicated Resident 110 had the carrot splint applied to the right hand for approximately three hours. The OT Encounter Note indicated Resident 110 had frequent emotional breakdowns and expressed feelings of hopelessness. During a review of Resident 110's OT Treatment Encounter Note, dated 10/24/2023, the OT Treatment Encounter Note indicated Resident 110 had joint tightness in the right hand and received stretching and ROM exercises. The OT Encounter Note indicated the carrot splint was applied to Resident 110's right-hand for two hours. During a review of Resident 110's OT Treatment Encounter Notes, dated 10/25/2023, 10/26/2023, 10/30/2023, 10/31/2023, 11/1/2023, 11/3/2023, 11/6/2023, and 11/7/2023, the OT Treatment Encounter Notes did not include the application of the right-hand carrot splint. During a review of Resident 110's OT Recertification, dated 11/7/2023, the OT Recertification indicated Resident 110 continued to require minimal assistance for self-feeding. Resident 110's OT Recertification included an OT goal for Resident 110 to perform self-feeding tasks with contact guard assistance. The OT Recertification did not include for Resident 110 to use built-up utensils for self-feeding and did not include the use of a right-hand splint. The OT Plan of Treatment for Resident 110 included therapeutic exercises, neuromuscular reeducation, therapeutic activities, and self-care management training four times per week for four weeks. During a review of Resident 110's OT Treatment Encounter Notes, dated 11/8/2023, 11/10/2023, 11/13/2023, and 11/14/2023, the OT Treatment Encounter Notes did not include the application of the right-hand carrot splint. During a review of Resident 110's OT Treatment Encounter Note, dated 11/15/2023, the OT Encounter note indicated Resident 110 received PROM to both arms and utilized the left (non-dominant) arm during hygiene and grooming. The OT Treatment Encounter Note did not include the application of the right-hand carrot splint. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 110's OT Treatment Encounter Note, dated 11/16/2023, the OT Treatment Encounter Note, indicated Resident 110 received PROM to both arms. The OT Treatment Encounter Note indicated Resident 110's right hand had skin redness and inflammation in all digits of the right hand, nursing (unknown) was notified, and the right arm was elevated. The OT Treatment Encounter Note did not include the application of the right-hand carrot splint and did not indicate Resident 110 received pain medication. During a review of Resident 110's OT Treatment Encounter Note, dated 11/20/2023, 11/21/2023, 11/22/2023, 11/23/2023, 11/24/2023, 11/28/2023, 11/29/2023, 11/30/2023, and 12/1/2023, the OT Treatment Encounter Note did not include the application of the right-hand carrot splint. During a review of Resident 110's MDS, dated [DATE], the MDS indicated Resident 110 had clear speech, usually expressed ideas, and wants, usually understood verbal content, and improved to intact cognition. The MDS indicated Resident 110 required partial/moderate assistance (helper does less than half the effort) for eating and personal hygiene. The MDS indicated Resident 110 had ROM impairments in one arm and did not have any impairments in either leg. During a review of Resident 110's OT Recertification, dated 12/5/2023, the OT Recertification indicated Resident 110 tolerated a right-hand roll for less than one hour. The OT Recertification indicated a new OT goal for Resident 110 was to tolerate a right-hand roll for four to six hours for contracture management. The OT Plan of Treatment for Resident 110 included orthotic (splint) management, therapeutic exercises, neuromuscular reeducation, therapeutic activities, and self-care management training four times per week for four weeks. During a concurrent observation and interview on 1/8/2024 at 2:18 PM in Resident 110's bedroom, Resident 110 described his right hand as a claw which he could not open. During a concurrent observation and interview on 1/9/2024 at 11:20 AM in Resident 110's bedroom, Resident 110 was awake, alert, and moving his left arm actively while lying in bed. Resident 110 was asked to move the right arm, but Resident 110 stated, I do not have a right arm. Resident 110's right hand was in a closed fist position with the forearm positioned in supination (turned with the palm facing upward). Resident 110 slightly lifted the right arm at the shoulder and elbow joints to bend and extend the arm. Resident 110 stated the therapists (in general) did not assist with opening the right hand but placed a splint inside the right hand every one or two days. Resident 110 stated it had been two days since a splint was placed in the right hand and felt that the hand splint was not working. Resident 110 stated, One of my reasons for being here (at the facility) was to build the body, not regress (returning to a less developed state). And I have regressed. During an interview on 1/12/2024 at 8:55 AM in Resident 110's bedroom, Resident 110 stated he was right-hand dominant and initially felt numbness in the right hand. Resident 110 stated the fingertips started to bend, like a claw, and then gradually tightened up into a fist. Resident 110 stated the therapists first started putting a carrot splint in the right hand three days per week. Resident 110 stated the carrot splint did not assist with loosening his fingers, did not fit properly, and did not have a strap to secure it to the right hand. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 1/10/2024 at 1:27 PM in Resident 110's bedroom, Resident 110 was awake, alert, lying flat in the bed. Resident 110 had a hand roll splint applied to the palm of the right hand which was secured with a strap across the back of the palm. Resident 110 stated he currently used the left hand to eat meals. Resident 110 became emotional with both eyes tearing up and stated he was feeling miserable, helpless, and hopeless due to his gradual decline in function (activity or purpose natural to or intended for a person). During a concurrent interview and record review on 1/11/2024 at 11:39 AM with the Director of Rehabilitation (DOR) and the ADOR, the DOR and the ADOR reviewed Resident 110's clinical records. The DOR stated Resident 110 received an OT Evaluation on 6/27/2023 (upon readmission), which indicated Resident 110 did not have any contractures and both hands had WFL ROM. The DOR reviewed Resident 110's Rehab - Joint Mobility Screening, dated 7/21/2023, which indicated Resident 110's right hand had a severe impairment. During a concurrent interview and record review on 1/11/2024 at 12:10 PM with the DOR and OT 1, OT 1 stated Resident 110 could actively move both arms, including the right hand, during the OT evaluation on 6/27/2023 (upon readmission). The DOR and OT 1 stated it was a significant change for Resident 110 to progress from WFL in the right hand to severe ROM impairment in the right hand. During an observation and interview on 1/11/2024 at 12:56 PM with the DOR and OT 1 in Resident 110's bedroom, Resident 110 stated, I was always right-handed. Resident 110 stated he felt pain from the right hand all the way up the right arm and stated, I just want to saw it (the right arm) off. Resident 110's right hand was positioned in a fist when OT 1 attempted to passively extend the fingers. Resident 110 moaned and stated he felt a sensation of pain in the right hand. Resident 110 was unable to extend any fingers on the right hand upon OT 1's request. OT 1 stated Resident 110's right hand was tight with severe limitations in all finger joints of the right hand. Resident 110 attempted to bend the right wrist but again moaned with pain. OT 1 stated Resident 110's right wrist ROM was severely limited due to pain. Resident 110 bent and extended the right elbow joint but only slightly lifted the right arm at the shoulder joint. OT 1 attempted to perform PROM to the right shoulder joint but stated Resident 110 could not tolerate additional movement due to pain. OT 1 stated Resident 110 was more alert, awake, and verbal compared to the initial OT evaluation on 6/27/2023 when Resident 110 was nonverbal and dependent. OT 1 stated Resident 110 used to move the right arm but now has right-hand tightness and limited movement due to pain in the right arm. During a review of Resident 110's OT Treatment Encounter Note, dated 1/11/2024 signed by OT 1, the OT Treatment Encounter Note indicated Resident 110 had severe ROM impairment (25% or less of full ROM) in the right shoulder, minimal ROM impairment (approximately 75% of full ROM) in the right elbow, moderate ROM impairment (50% of full ROM) due to pain in the right wrist, and severe ROM impairment to the right hand. During a concurrent interview and record review on 1/11/2024 at 2:42 PM with the DOR, the ADOR, and COTA 1, COTA 1 reviewed the OT Treatment Encounter Note, dated 7/6/2023. COTA 1 stated Resident 110 performed exercises to both arms during the treatment session. COTA 1 stated Resident 110 grabbed onto a dowel rod (thin, straight bar made of wood, plastic, or metal) using both hands and required assistance to lift the dowel to perform the exercises. COTA 1 stated Resident 110's right hand was in a closed position, and COTA 1 may have seen a sign of Resident 110's right hand becoming tight. COTA 1 stated a rolled-up towel was placed in the right hand as a contracture prevention measure. (continued on next page)

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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 0688 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 1/11/2024 at 2:42 PM with the DOR, the ADOR, and OT 1, OT 1 reviewed the OT Treatment Encounter Note, dated 8/1/2023, which indicated Resident 110 received the right-hand carrot splint. OT 1 stated Resident 110's OT Progress Note, dated 8/7/2023, included a new OT goal to wear the hand roll on the right hand for up to four hours. The DOR, the ADOR, and OT 1 reviewed Resident 110's OT Evaluation, dated 9/12/2023, which indicated Resident 110 did not have any contractures but had impaired ROM to the right hand. The DOR, the ADOR, and OT 1 stated Resident 110's right hand was not assessed due to Resident 110's complaint of pain. The DOR, the ADOR, and OT 1 stated Resident 110's goal for the right-hand splint was removed, but OT 1 stated Resident 110's OT goal for the hand splint should have been continued. During an interview on 1/11/2024 at 5:44 PM the OT 1 stated any resident (in general) with ROM impairments should have a splint applied to prevent tightness and contracture development. During a concurrent interview and record review on 1/11/2024 at 6:12 PM with the DOR and the Director of Nursing (DON), the DON reviewed Resident 110's physician's orders and stated Resident 110 had a physician's order for Tylenol as needed for pain management. The DON reviewed Resident 110's MAR and stated pain medication was never administered to Resident 110 during months from 6/2023 to 1/2024. The DOR stated Resident 110's right hand splint was not applied for at least two months between 10/2023 and 12/2023. The DOR stated Resident 110's right hand ROM decline was preventable if the right-hand splint had been applied. During an interview on 1/12/2024 at 9:03 AM with Resident 110's consulting physiatrist ([MD 1], specialist physician who treat patients with injuries or suffer from disabilities that affect physical and cognitive functioning), MD 1 stated Resident 110 was clinically diagnosed (diagnosis made on basis of medical signs and reported symptoms, rather than diagnostic tests) with Dupuytren's contracture (an abnormal thickening of tissues in the palm of the hand) on the right hand. MD 1 stated Resident 110's right hand began to bend at the right ring and little fingers, but MD 1 stated Resident 110 could still use the right thumb, index, and middle fingers to eat. MD 1 stated Dupuytren's was a progressive (disease or physical ailment whose course in most cases is the worsening, growth, or spread of the disease) and had three options for treatment to temporarily slow down the progression. MD 1 stated one treatment included providing ROM and a splint to Resident 110's right hand. During a concurrent interview and record review on 1/12/2024 at 9:56 AM with OT 1, OT 1 reviewed Resident 110's OT Evaluation on 6/27/2023 which included Resident 110's OT goal for hygiene and grooming, OT Recertification on 7/25/2023 which included a goal for self-feeding using built-up utensils, and OT Recertification on 8/22/2023 which included a goal for self-feeding using built-up utensils. OT 1 stated the OT goals were established for Resident 110 to use the right, dominant hand for self-feeding, hygiene, and grooming to maintain function in the right arm. During an interview on 1/12/2024 at 11:04 AM via telephone with OT 2, OT 2 stated Resident 110 was resistant to PROM and touch on the right-hand due to pain during the OT Evaluation on 9/12/2023. OT 2 stated nursing was notified of Resident 110's pain but did not remember if Resident 110 received pain medication. OT 2 stated the right-hand splint was not an appropriate goal during the OT Evaluation since Resident 110 did not allow OT 2 to touch the right hand due to pain. OT 2 did not remember if Resident 110 received any pain medication. OT 2 stated the purpose of a splint was for contracture management and to increase ROM. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/12/2024 at 11:24 AM with the CRT, the CRT stated residents (in general) experiencing pain should receive pain medication prior to any treatment. The CRT stated Resident 110 should have received pain medication prior to the OT assessment on 9/12/2023 to participate in the OT assessment. The CRT stated Resident 110's pain was not a reason to remove the OT goal for the right-hand splint application. During an interview on 1/12/2024 at 1:44 PM via telephone with Resident 110's Responsible Party (RP 1), RP 1 stated Resident 110 was healthy prior to living at the facility. RP 1 stated Resident 110 never ever had any issues with the right hand. RP 1 told the facility staff (unknown) that Resident 110's right hand was not working and asked about treatment options, including surgery, to help improve the right hand. RP 1 stated a carrot splint was placed to the right hand but did not feel it was effective treatment for the fingers and the pain. During a review of the facility's Policy and Procedure (P&P) titled, Resident Mobility and Range of Motion, revised 7/2017, the P&P indicated Residents will not experience an avoidable reduction in ROM. The P&P also indicated Interventions may incl [TRUNCATED]

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on observation, interview and record review, the facility failed to ensure one of one sampled residents' (Resident 75) oxygen (a treatment that provides supplemental [essential air] to the body) tubing was dated. This failure had the potential for Resident 75's oxygen tubing to be replaced untimely which could inadvertently affect the delivery and/ or patency (the condition of being open) and quality of the oxygen tubing and can pose as a risk for infections. Findings: During a review of Resident 75's Admission Record, the Admission Record indicated Resident 75 was admitted at the facility on 3/10/2010 and readmitted on [DATE] with a diagnoses that included cerebral infarction (a condition also known as stroke that occurs when the blood supply to the brain was interrupted or blocked causing damage to the tissues of the brain) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and eventually the ability to carry out the simplest tasks) and a history of acute respiratory failure (a condition that occurs when the lungs cannot release enough oxygen into the blood, which prevents the organs of the body from functioning properly). During a review of Resident 75's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 1/5/2024, the MDS indicated Resident 75 was unable to make decisions regarding tasks for himself, had no difficulty in hearing and was totally dependent to two-person assist to complete his activities of daily living (ADLs) such as bed-to-chair and vice versa transfer, toileting and personal hygiene. During a review of Resident 75's medical record titled, Order Summary Report dated 11/13/2023, the Order Summary Report indicated Resident 75 had an order to for supplemental oxygen at two liters (the flow of oxygen received from the oxygen delivery device) per minute to keep his oxygen saturation (the measurement of the level of oxygen in the blood) at 93% and above through an oxygen concentrator (an oxygen delivery device) every shift. During a review of Resident 75's medical record titled, Order Summary Report dated 11/13/2023, the Order Summary Report indicated Resident 75 had an order for a nasal cannula (a device that delivers extra oxygen through a tube and into the person's nose) and humidifier (a medical device that delivers supply comfortable moisturized oxygen) to be changed every week in the morning shift (7:00 a.m. to 3:00 pm shift). During an observation on 1/8/2024 at 10:52 a.m., with Resident 75, Resident 75 was in his room napping and he had supplemental oxygen continuously administered through a nasal cannula at two liters per minute; however, the oxygen tubing was undated (no date). Licensed Vocational Nurse 1 (LVN 1), who was rounding the resident care areas confirmed the oxygen tubing of Resident 75 was undated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/10/2024 at 9:07 a.m., with LVN 1, LVN 1 stated the residents' oxygen tubing is changed every week and must be dated to ensure patency and prevent risk of infection to the residents. During an interview on 1/10/2024 at 9:40 a.m., with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated if the oxygen tubing has no date, it is a risk for infection control. During an interview on 1/10/2024 at 10:37 a.m., with the Director of Nursing Services (DON), the DON stated there is no excuse for the residents' oxygen tubing to be undated as there is an order for the nasal cannula to be changed weekly, as reflected in the facility's policy. During a review of the facility's policy and procedure (P/P) titled Oxygen and Nebulizer-Prevention of infection revised 11/2011, the P/P indicated the facility must prevent infection associated with respiratory tasks and equipment, among residents and staff by changing the oxygen cannula and tubing every 7 days, per manufacturer's recommendations, or as needed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview and record review the facility failed to: 1. Ensure one opened bottle of latanoprost (a medication used to treat eye problems) eye drops stored at room temperature was labeled with an open date affecting Resident 73 in one of five inspected medication carts (Palm Villa South Cart.) This deficient practice of failing to store or label medications per the manufacturers' requirements increased the risk that Residents 73 could have received medication that had become ineffective or toxic due to improper storage or labeling possibly leading to health complications resulting in hospitalization or death. Findings: During a record review of Resident 73's Admission Record, the record indicated an admitted [DATE] with the diagnosis including dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities). During a record review of Resident73's Minimum Data Set ([MDS]- a standardized screening and care assessment tool) dated 12/21/2023, the MDS indicated Resident 73's cognitive (thinking and reasoning) skills was severely impaired with daily decision making. During a concurrent observation and interview on 1/9/24 at 1:42 PM of Palm Villa South Cart with the Licensed Vocational Nurse (LVN 2), the following medications was found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 1. One bottle of latanoprost eye drops for Resident 73 was found open but not labeled with an open date. According to the manufacturer's product labeling, once opened, latanoprost may be stored at room temperature for up to six weeks. LVN 2 stated the latanoprost eye drops for Resident 73 are opened and are not labeled with an open date. LVN 2 stated latanoprost eye drops need to be labeled with an open date once open and stored at room temperature to know when they'll expire. LVN 2 stated that administering expired medications to residents could cause clinical complications possible resulting in hospitalization . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy Storage of Medications, last updated August 2019, indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations of those of the supplier . Medications requiring refrigeration .are kept in a refrigerator with a thermometer to allow temperature monitoring . Outdated, contaminated, or deteriorated medications . are immediately removed from stock, disposed of according to procedures for medication disposal.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46036 Based on observation, interview, and record review, the facility failed to follow up on necessary dental services for one of two sampled residents (Resident 86). This deficient practice had the potential to cause a delay in treatment and place Resident 86 at risk for infection, pain and degraded self-esteem. Findings: During a review of Resident 86's Admission Record, the Admission Record indicated Resident 86 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), schizophrenia (a mental illness characterized by hearing and seeing things that are not there), and dementia (impaired ability to remember, think or make decisions that interferes with doing everyday activities). During a review of Resident 86's Minimum Data Set (MDS), standardized assessment and care screening tool, dated 12/21/2023, the MDS indicated Resident 86's cognitive skills (relating to the process of acquiring knowledge and understanding) for daily decision making was moderately impaired. During a concurrent observation and interview on 1/8/2024 at 11:35 a.m., with Resident 86, Resident 86 was pointing to his mouth and stated he needed a new tooth. Resident 86 was observed to have many missing teeth and the remaining front teeth were broken with some black areas on the surfaces. Resident 86 denied pain or discomfort. Resident 86 stated, I need a new tooth. During a review of Resident 86's Oral Health Care note dated 1/03/2023, the note indicated all teeth are broken at or below the gum line and referral (to dental care) was needed. No sign of infection noted. No pain per patient. During a review of Resident 86's Psychosocial Assessment and Social History, dated 3/19/2023, the record indicated Resident 86 was seen by Oral Health on 01-25-2022, and does not wear dentures. The record indicated, Resident 86 had missing top and bottom teeth, and will schedule follow up appointment. During a review of Resident 86's Order Summary Report, the order summary report indicated Resident 86 had a physician's order, dated 11/08/2023, for Dental consult and treatment as indicated for dental issues. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/12/2024 at 10:10 a.m., with Registered Nurse Supervisor 2 (RNS)2, RNS 2 stated our dentist comes and checks all residents every month. RNS 2 stated, if the dentist identifies a resident has an urgent dental matter or that referral treatment was needed, the dentist would inform the nurses and the nurses notified the primary medical doctor (MD). RNS 2 stated, after MD placed an order for follow up treatment, the Social Service department was responsible contacting the facilitie's Dental Group to follow up with any treatment including appointment or billing. RNS 2 stated, the process would normally take two-to-three days to be completed. RNS 2 stated, dental service is important for residents because it enhances resident's sensory enjoyment of food which is very essential for their quality of life and dignity. During a concurrent interview and record review on 1/10/2023 at 1:48 p.m., with Social Services Director (SSD) 1, SSD 1 stated he is currently working on evaluation for some of Resident 86's teeth and possible dentures. SSD 1 reviewed the interdisciplinary (IDT, the residents health care team consisting of various specialties) meeting minutes from 01/2023-09/2023, and stated, there was no documented evidence that IDT team discussed the bad condition of Resident 86's teeth and the services needed to prevent further infection. SSD 1 stated, dental treatment should have been done in a timely manner because it may lead to the spread of infection from the tooth to the rest of the body. During a review of facility's policy and procedure (P/P) undated, titled Availability of Services, Dental, the P/P indicated all requests for routine and emergency dental services should be directed to Social Services to assure that appointments can be made in a timely manner.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview, and record review the facility failed to follow menus and standardized recipe for: a.49 of 224 residents on minced and moist /soft bite by pouring milk in the corn bread recipe without using a measuring cup. b.89 of 224 residents on regular texture by not weighing portions of Baked Ham. c.24 of 224 residents on puree diet (diet that contains food with pudding like consistency) received puree cabbage with fibrous residues. These deficient practices had the potential to cause decrease food intake resulting to unintentional weight loss, increase food intake resulting to unintentional weight gain and potential choking(when a person can't speak, cough, or breathe because something is blocking the airway) for residents on puree diet. Findings: a.During an observation of the Dietary Aide 4 (DA 4) portioning of corn bread on 1/8/2024 at 11:26 AM by the preparation area, DA 4 poured whole milk on the corn bread without using a measuring cup. During an interview with DA 4 on 1/8/2024 at 11:33 AM, DA 4 stated she poured a quarter gallon to the corn bread and made it slurry (a semi-liquid mixture). During an interview with Food Service Director (FSD) on 1/8/2024 at 11:42 AM, FSD stated DA 4 poured milk and not water due to weight loss issues of the residents on minced and moist diet. FSD stated the Registered Dietitian (RD) was aware of this practice however, the recipes were not reviewed and modified yet as it was new, and it was the first day of implementation. During an interview with the Registered Dietitian 1 (RD 1) and FSD on 1/8/2024 at 11:45 PM, RD 1 stated she was aware of adding milk instead of water to the minced and moist corn bread due to weight loss issues however, the menu was new and has not been reviewed yet. FSD stated pouring of milk on the corn bread was eyeballing the amount of milk and not using measuring cups would not be an accurate measurement of the ingredients providing more or less nutrients to the residents. FSD stated measuring utensils were available in the kitchen and that staff should be using it. A review of the facility's menu spreadsheet cycle 1 dated 1/8/2024 and approved by a Registered Dietitian 1 (RD 1) on 1/7/2024, indicated minced and moist (slightly wet) and soft bite sized (moist 0.5 inch or 1.5 cm size) would receive moist corn bread, one (1) each. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's recipe titled Moist Corn Bread/[NAME] not dated, indicated Ingredient: Corn bread, Thickener, Food, TSBP powder, water, margarine, pat. Method: Slurry for dysphagias: for every 8 portions needed. Prepare a slurry with 2 tbsp thickener and 2 cups warm liquid (water or juice); mix well with wire whip. Pour 1/2 of the slurry into a baking pan. Place the squares of cake into the pan (sitting in the slurry). Pour remaining slurry over each piece of cake. Let stand for at least 20 minutes before serving with a wide turning spatula. A review of facilities' Policies and Procedures (P&P) titled Menu Planning, dated 10/11/2023 indicated Standardized recipes adjusted to appropriate yield shall be maintained and used in food preparation. A review of the facilities P&P titled Menu Planning, dated 10/11/2023 indicated The menus are planned to meet nutritional needs of residents in accordance with established national guidelines, Physician's orders and, to the extent medically possible, in accordance with the most recent recommended dietary allowances of the Food and Nutrition Board of the National Research Council National Academy of Sciences. Menus are to be approved by the facility Registered Dietitian prior to the beginning of each quarterly menu cycle. A review of the facility's Job Description titled Cook A and Cook B undated, indicated, (3) Ability to accurately measure food ingredients and portions. b. During an observation of the lunch trayline on 1/8/2023 at 12:10 PM, Cook 1 was serving three (3) pcs of baked ham on the trays. During a concurrent observation of weighing of the ham pieces on 1/8/2023 at 1:09 PM and interview with the FSD, 3 pcs of the ham weighed five (5) ounces (oz, a unit of measurement), another 3 pcs of ham weighed four (4) oz and 3 pcs of small portions weighed 3 oz. FDS stated Cook 1 was the one who cut the ham and it was eyeballed and not weighed when cook 1 sliced the ham. During an interview with Cook 1 and Diet Assistant 1 on 1/8/2024 at 9:30 AM, Cook 1 stated she sliced the ham using a knife and was aware that serving sizes were 3 oz for regular diet and 4 oz of large portions. Cook 1 stated she cut the ham but only weighed 120 pcs of the ham and the rest of the portions she eyeballed it. Cook 2 stated she should have weighed the ham as it could affect food intake of the residents however could not verbalized why. Diet Assistant 1 stated portion sizes would not be accurate if eyeball method was use and if weighing scale or scoop sizes were not used in determining portion sizes of food. Diet Assistant 1 stated residents would not get the calories and proteins they needed. Diet Assistant 1 stated resident who got more could gain weight and residents who got less could potentially lose weight. A review of the facility's recipe titled Baked Ham, not dated, indicated. Suggested portion 3 oz. (4) Serve one slice per portion. A review of facilities' P&P titled Menu Planning, dated 10/11/2023, indicated, Menus are planned to consider (c) Available equipment necessary for preparation and serving of food. c. A review of the facility's menu spreadsheet cycle 1 dated 1/8/2024 and approved by a Registered Dietitian 1 (RD 1) on 1/7/2024, indicated Puree diet included the following items on the tray: (continued on next page)

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Artesia Palms Care Center	11900 E. Artesia Blvd. Artesia, CA 90701

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Puree baked ham # 8 scoop (1/2 cup) Puree seasoned beans #8 scoop (1/2 c) Puree smothered cabbage # 6 scoop (2/3c) Puree corn bread #12 scoop (1/3 c) Margarine 1 each Spice cake with frosting #12 scoop (1/3 c) Beverage 8 oz Whole milk 8 oz During a test tray conducted on 1/8/2024 at 2:04 PM for Puree diet with the FSD and RD 1, puree smothered cabbage had small, fibrous residue and the texture was not smooth pudding like consistency. Puree smothered cabbage had little lumps of cabbage and carrots. RD 1 stated puree cabbage and carrots had a little residue when I tried it. RD 1 stated puree food should not have a residue but questioned to what extent. RD 1 stated the little residue was fiber in the cabbage. During an interview with the Speech Therapist 1 (ST 1) on 1/8/2024 at 4:14 PM, ST 1 stated he tasted the puree cabbage, and it had a little fiber residue, however it would not cause any choking or swallowing problems in his opinion. A review of facilities' recipe titled P Smothered Cabbage not dated, indicated, Method: 1 Drain portions needed from regular recipe. Place into a food processor, process to a fine texture. 2. Add thickener and process until smooth, with a rubber spatula, scrape down sides of the bowl. A review of facilities' P&P titled Menu Planning, dated 10/11/2023, indicated, The facilities' diet manual and the diets ordered by the physician should mirror the nutritional care provided by the facility. Menus are planned to consider (f) Texture and color of all foods in meals. A review of facilities' diet manual titled Dysphagia Diets, Puree-IDSSI Level 4 approved by RD 1 on 8/1/2023, indicated, (3) Puree foods do not require chewing. They should have a pudding like consistency without lumps (i.e., sour cream or mayonnaise thickness/moistness). All foods are appropriate if the consistency is pureed smooth, without fibrous particles. Gravy or sauce maybe added for lubrication or flavor enhancement. All prepared puree recipes should be tested prior to service to ensure the texture meets the IDDSI guidelines.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47441 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: a. One (1) of 1 Dietary Aide touched the trash can cover after performing hand hygiene then put new gloves on. b. A mixer was stored on the floor and the mixer's bowl guard had dough build up and residues. c. Walk-in freezer and reach in freezer were full of food boxes causing poor air circulation and ice build-up. d. Pots and pans were not air dried. e. Two (2) of 2 staff were wearing a watch and a gold bracelet. f. One (1) staff cut the spiced cake and the corn bread using the same knife without washing the knife in the dishwashing machine. (Cross-contamination- transfer of harmful bacteria from one place to another). g. Dishwashing temperature records were blank for lunch and dinner on 1/8/2024. h. Three (3) of 3 kitchen staff were not following manufacturer's guidelines for sanitizer test strips. i. A Tupperware of food was found in the resident's refrigerator at the Villa unit not labeled and dated. j. Resident's refrigerator had ice buildup, December 2023 temperature logs were blank, and freezer had no thermometer and was not checked and monitored. These failures had the potential to result in harmful bacteria growth and cross contamination that could lead to foodborne illness (an illness caused by contaminated food and beverages) for 222 of 224 medically compromised residents who received food from the kitchen. Findings: a. During an initial kitchen tour observation of the handwashing process of Dietary Aide 1 (DA 1) on 1/8/2024 9:11 AM, DA 1 touched the garbage can cover to throw the paper towel after washing his hands then put on gloves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Food Service Director (FSD) and DA 1 on 1/8/2024 at 9:13 AM, FSD stated she ordered a foot operated trash can however, it was red in color that could be mistaken for a hazardous waste hence they did not use it. DA 1 stated that he touched the garbage cover after washing his hands and he should have not done that to prevent cross contamination that could make residents sick. DA 1 stated he should have washed his hands before putting on fresh gloves and pursuing his work. A review of the facility's Policy and Procedure (P&P) titled Handwashing/Hand Hygiene, revised 10/11/2023, indicated, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Hand hygiene is indicated: c. after contact with blood, body fluids, or contaminated surfaces. A review of Food Code 2017 indicated, 2-301.14 When to Wash. Food employees shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: (E) After handling soiled equipment or utensils. (I) After engaging other activities that contaminate the hands. b. During a concurrent initial kitchen tour observation of the mixer on 1/8/2024 at 9:38 AM and interview with the FSD, Mixer was stored on the floor and the mixer's bowl guard had dough build up and residues. FSD stated she ordered a table to elevate the mixer to prevent cross contamination. FSD stated the last time the mixer was used was last week. FSD stated the mixer bowl guard needed to be cleaned to prevent cross contamination. A review of the facility's P&P titled Electrical Food Machines, revised 10/11/2023, indicated Keep and maintain all food machines in good operating, sanitary conditions. This includes mixers, grinders, slicers, and toasters. Mixing Machines (1) Wash the bowl and beater after each use. (3) Clean the beater shaft and body of the machine with warm water and detergent following manufacturer's instructions. A review of Food Code 2017 indicated 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be clean to sight and touch. (B) Nonfood-Contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. c. During initial kitchen observation of the Freezer 2 on 1/8/2024 at 9:47 AM, Freezer 2 was packed with food boxes . During a concurrent kitchen tour observation of the walk-in freezer on 1/8/2024 at 9:51 AM and interview with FSD, walk-in-freezer was packed with food boxes stored. Walk-in freezer ceiling had ice buildup on the ceiling. FDS stated she was aware of the poor circulation and the staff will defrost products today to free up some space for proper air circulation. During a concurrent kitchen tour observation of the ice box on 1/8/2024 at 10:12 AM in the tray line area and interview with FDS, the ice box had thick ice buildup. FDS stated the ice box needed cleaning for temperature maintenance. During an observation of the walk-in freezer on 1/9/2024 at 9:26 AM, walk-in freezer was packed with food boxes without proper air circulation. Walk-in freezer ceiling had ice buildup. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of the Freezer 2 on 1/9/2024 at 9:29 AM, Freezer 2 was packed with food boxes A review of the facility's P&P titled Procedure for Refrigerated Storage, indicated (5) Food should be covered and stored loosely to permit circulation of air. Do not overload the refrigerator. Overloading may prevent airflow and make the unit work harder to stay cold. d. During a concurrent observation of the pots and pans on 1/8/2023 at 10:06 AM, in the storage room and interview with the FSD, pots, pans and food containers were stacked wet. FSD stated the food containers should not be stored and stacked wet due to the possible growth of bacteria. A review of the facility's P&P titled Dish Washing, dated 10/11/2023, indicated (5) Dishes are to be air dried in racks before stacking and storing. A review of Food Code 2017 indicated 4-901.11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining. (B) May not be cloth dried. e. During an observation of the Diet Aide 2's (DA 2) dish washing process on 1/8/2024 at 11:15 AM in the dish washing machine area, DA 2 was wearing a wristwatch and a gold bracelet while putting away clean dishes. During an observation of the Diet Aide 3(DA)'s checking of meal trays on 1/8/2023 at 1:43 PM in the tray line area, DA 3 was wearing a wristwatch while checking lunch meal trays. During an interview of the FSD on 1/8/2024 at 1:59 AM, FSD stated staff were allowed to wear minimal hand jewelries, religious emblems, and wedding rings. FSD stated staff are allowed to wear watches for as long as it was not touching the food. FSD stated facilities does not allow staff wearing jewelries and watches in food service for infection control purposes as it could potentially cause cross contamination when it touched the food. During an interview with the DA 2 on 1/9/2024 at 10:15 AM, DA 2 stated he was not allowed to wear a bracelet and a watch due to cross contamination however, he covered it with his gloves. During an interview of the DA 3 at 1/10/2024 at 10:15 AM, DA 3 stated she wore her wristwatch for medical reasons and was allowed by FSD to wear it. During an interview with the FSD on 1/10/2024 at 10:37 AM, FSD stated one (1) employee was allowed to wear a watch due to medical reasons FSD unable to provide medical necessity requirements that is necessary for DA 3. During a review of the facility's P&P titled Dress Code, dated 10/11/2023, indicated Proper Dress (7) No excessive jewelry, just wedding ring on hand, no dangling earrings on ears. Not watches unless medically necessary. During a review of Food Code 2017 indicated 2-303.11 Prohibition. Except for a plain ring such as wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. During an observation of Diet Aide 4 (DA 4) cutting of spiced cake and corn bread on 1/8/2024 at 11:26 AM, one (1) knife was used to cut the spiced cake and the corn bread after each use ,observed DA 4 rinsed the knife in the preparation sink and wiped the knife with a paper towel. During an interview with the FSD on 1/8/2024 at 11:42 AM, FSD stated the preparation sink was used for preparation of food and there was no washing done in the sink. During an interview with the DA 4 and Registered Dietitian 1 (RD 1) on 1/9/2024 at 10:32 AM, RD 1 stated staff cannot wash anything on the preparation sink to prevent cross contamination and staff could not use the same knife for different foods. DA 4 stated she rinsed the knife that she used to slice the spiced cake in the preparation sink; then wiped the knife with a paper towel to remove the cake residue so she could make the cake moist and wet. DA 4 stated she could not use the same knife for two (2) different recipes due to cross contamination. DA 4 stated she only sliced the corn bread. During a review of Food Code 2017 indicated Preventing Food and Ingredient Contamination 3-302.11 Packaged and Unpackaged Food-Separation, Packaging, and Segregation. (3) Cleaning equipment and utensils as specified under 4-602.11 and sanitizing under as specified under 4-703.11. During a review of Food Code 2017 indicated 4-602.11 Equipment Food Contact-Surfaces and Utensils (A) Equipment food contact surfaces and utensils shall be cleaned: (5) At any time during the operation when contamination may have occurred. g.During an observation of and record review of the Dishwashing Temperature/Sanitizer Record on 1/9/2024 at 10:07 AM, dishwashing temperature records for 1/8/2024 for lunch and dinner were blank. Dishwashing Temperature/Sanitizer Record dated 1/2024, indicated Instructions: Please record wash and rinse temperature, and chlorine ppm (parts per million, concentration of the solution) before each meal. During an interview with the DA 3 on 1/10/2024 at 9:49 AM, DA 3 stated she was the one responsible for recording the dish machine temperature on 1/8/2024 for lunch and dinner but got distracted by other work in the kitchen and forgot to record the dish machine temperatures. DA 3 stated, it is important to monitor, check and record the dish machine temperatures to ensure accuracy of the temperature and make sure the dish machine was killing the bacteria during dishwashing. A review of the facility's P&P titled Dish Washing, dated 10/11/2023, indicated, (8) A temperature log (and chlorine log for low-temperature machines) will be kept and maintained by dishwashers to assure that the dish machine is working correctly. This log will be completed each meal prior to any dishwashing. A review of Food Code 2017 indicated 4-204.113 Ware washing Machine, Data Plate Operating Specifications. A ware washing machine shall be provided with an easily accessible and readable data plate affixed to the machine by the manufacturer that indicates the machine design and operation specification including the: (A) Temperatures required for washing, rinsing, and sanitizing; (B) Pressure required for the fresh water sanitizing rinse unless the machine is designed to use only a pumped sanitizing rinse. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. During a concurrent observation of DA 2 quat sanitizer testing demonstration on 1/9/2024 at 10:15 AM and interview with DA 2, DA 2 filled the red bucket with quat sanitizer, then dipped and agitated the test strips into the foamy sanitizer for 20 seconds (using a phone timer). DA 2 then compared the test strips to the color chart. DA 2 stated he does not follow a particular time as to how long he dipped the test strips into the sanitizer solution and just waited for it to turn green. DA 2 stated, he compared the test strips with the color chart once it turned green. DA 2 then read the manufacturer's guidelines printed on the back of the sanitizer strips and stated he dipped the test strips longer. DA 2 stated he did not follow the manufacturer's guidelines hence it could affect the readings of the sanitizer affecting the concentration of the solution. DA 2 stated if the reading was not accurate, it was possible for the sanitizer not to kill bacteria on the surfaces that they cleaned. During a concurrent observation of the DA 3 quat sanitizer testing demonstration on 1/10/2024 at 10:05 AM and interview with DA 3, DA 3 filled the read bucket with a pre-mix sanitizer in the dishwashing area then dipped and shook the test strips in to the quat sainting solution while counting 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1010. DA 3 compared the test strips to the color chart. DA 3 stated she dipped the test strips into the sanitizing solution for 10 seconds then compared it to the color strips with an acceptable parts per million (ppm) concentration of 200-400 ppm. DA 3 stated she missed some steps for testing the sanitizer after reading the instruction printed at the back of the test strips. DA 3 stated that it was important to follow the manufacturer's guidelines for testing to ensure the sanitizer was effective to kill germs. DA 3 temped the sanitizing bucket and it was at 64.7 F. During a concurrent observation of the FSD's quat sanitizer testing demonstration on 1/10/2024 at 10:37 AM and interview with FSD, FSD filled up the red bucket, got the test strips and dipped and shook the test strip in the quat sanitizer solution while counting 1001,1002, 1003 .1010. FSD did not temped the solution before testing per manufacturer's guidelines. FSD stated the quat sanitizer was automatically mixed and dispensed and she checked if it was on the right ppm of 200-400 ppm by comparing it to the color chart. FSD stated that the manufacturer's instructions were not in the test strips that they currently use and that she was given an incorrect test strip by her assistant by accident; however, FSD verified that they use the same QT-40 test strip. FSD stated it was important to follow manufacturer's guidelines for the test strips to determine that sanitizer was effective to kill microorganisms that they do not see to the eye for their immunocompromised residents. A review of the facility's test strips instructions titled Hydrion QT-10, dated 1/31/2025, indicated Dip paper in quat solution, not foam surface, for ten (10) seconds. Don't shake. Compare colors at once. Testing solution should be between 65-75 F. Testing solution should have a neutral pH. Follow manufacturer's dilution instructions carefully. A review of the facility's log titled Quaternary Ammonium Log with temperature reading, undated indicated Instructions: Test the ammonium concentration in the quaternary sanitizer per policy and manufacturer's recommendation for solution temperature using the proper test strips. A review of Food Code 2017 indicated 4-501.116 Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. i. During an observation of the Resident's refrigerator on 1/9/2024 at 11:40 AM in the Villa unit's nurse's station, a Tupperware of chicken in the resident's refrigerator had no label and date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Licensed Vocational Nurse 2 (LVN 2) on 1/9/2024 at 11:40 AM, LVN 2 stated she needed to discard the Tupperware of chicken as it was not labeled nor dated. LVN 2 stated labeling and dating resident's food was important to identify who it belongs to and determine if food was still good to eat. A review of the facility's P&P titled Labeling and dating of foods, dated 10/11/2023, indicated All food items in the storeroom, refrigerator, and freezer needed to be labeled, and dated. A review of the facility's P& P titled Foods Brought by Family or Visitor, dated 10/11/2023, indicated It is the policy that food(s) brought to a resident by family/visitors must be accepted by the resident; inspected before facility storage; and stored and served in accordance with food safety professional standards. (5) Perishable prepared foods will be discarded after 3 days of storage. A review of Food Code 2017 indicated 3-501.17 Commercially processed food, open and hold cold, (B) except specified in (E) - (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacture's use-by- date if the manufacturer determined the use-by date based on food safety. j. During a concurrent observation of the resident's refrigerator and freezer in the Villa nurse's station on 1/9/2023 at 11:30 AM with the FSD, the refrigerator and freezer had ice buildup and there was no thermometer inside the freezer. FSD stated it was important for an ice buildup-free refrigerator and freezer to ensure the equipment would not malfunction and to ensure proper temperature of food. During an interview with LVN 2 on 1/9/2024 at 11:40 AM, LVN 2 stated the process of monitoring the refrigerator temperature was three times a day, but it was changed in January 2024 and the night shift staff were the ones doing it. LVN 2 stated the refrigerator and freezer needed cleaning however the maintenance log does not indicate that it needed cleaning. LVN 2 stated, there was no freezer thermometer in the freezer and there was no way for them to know if foods were stored on proper temperature. LVN 2 stated frozen product can melt and would no longer be safe to eat. LVN 2 stated she was not sure why the freezer temperatures were no longer checked. A review of the facility's refrigerator log titled Refrigerator Daily Temperature Record, dated 12/2023, indicated no temperature recorded on 12/29/2023, 12/30/2023 and 12/31/2023 or 7-3 AM and 3-11 PM shifts. A review of the facility's refrigerator log titled Refrigerator Daily Temperature Record, dated 1/2024, indicated refrigerator temperatures were only recorded once a day. A review of the facility's P&P titled Procedure for Refrigerated Storage, dated 10/11/2023, indicated (2) A temperature will be logged twice daily by a designated employee upon opening of the kitchen and upon closing of the kitchen. (3) Refrigerator equipment should be routinely cleaned. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled Procedure for Freezer Storage, dated 10/11/2023, indicated (2) Each freezer must have two thermometers that are easily visible. (3) Freezer temperatures should be recorded twice daily. A review of Food Code 2017 indicated Equipment Food-Contact Surfaces and Utensils (A) Equipment Food-Contact Surfaces and Utensils shall be cleaned: (5) Equipment is used for storage of packaged or unpackaged food such as reach-in refrigerator and the equipment are cleaned at a frequency necessary to preclude accumulation of soil residues. A review of Food Code 2017 indicated 3-304.11 Food Contact with Equipment and Utensils. Food shall only contact surfaces of: Equipment and utensils that are cleaned as specified under Part 4-6 of this Code and sanitized as specified under Part 4-7 of this code. A review of Food Code 2017 indicated 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45425 Based on interview and record review, the facility failed to ensure medical records were accurate for two of two sampled residents (Resident 74 and 195) when: a.the licensed nursing staff documented the clarification of an order for Resident 74 when Ivermectin (a medication to treat skin infections) was ordered and not given. b. The facility failed to document Resident 195's location every two hours as ordered by Resident 195's physcian: on 12/20/2023 and 1/1/2024 there was no documentation, on 12/29/2023, 12/31/2023, 1/2/2024, 1/5/2024 and 1/9/2024 there was no documentation during the night shift, and on 12/27/2023, 12/28/2023, 1/3/2024 and 1/4/2024 there was no documentation during the evening and night shifts. These deficient practices provided an inaccurate depiction of residents' status and care rendered to Resident 74 and 195. Findings a. During a review of Resident 74's admission record, the admission record indicated an admitted [DATE] with the diagnosis including schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). During a review of Resident 74's Minimum Data Set ([MDS]- a standardized assessment and care screening tool) dated 10/7/2023, the MDS indicated Resident 74's cognitive (thinking and reasoning) skills were moderately impaired. During a record review of the facility's skin sweep report dated 12/21/2023, the skin sweep report indicated Resident 74 skin was clear. During a record review of Resident 74's Dermatology Consultation Note, dated 12/27/2023, the note indicated Resident 74 had the diagnosis of dermatitis. The note indicated a plan to administer Ivermectin (medication to treat scabies) as a prophylaxis (preventative) treatment for dermatitis and previous exposure to scabies. During an interview and record review on 1/10/2024 at 10:37 a.m. with the TX 1, Resident 74's Dermatology consultation note dated 12/27/2023 and Resident 74's skin sweep report dated 12/21/2023 was reviewed. The Skin sweep report indicated Resident 74's skin was clear. The Dermatologist note indicated Resident 74 had dermatitis and previous exposure to scabies. TX 1 confirmed during skin sweep and on 12/27/2023 Resident74's skin was clear. TX 1 stated the dermatologist note was incorrect because Resident 74 did not have a rash the time the note was written, and Resident 74 was not exposed to scabies. TX 1 stated there should have been documentation Resident 74 was not exposed to scabies, did not have a rash, and the plan was not carried out because of an erroneous note by the Dermatologist. The Note should have been clarified with the physician. TX 1 stated there should have been a follow up note by the physician. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 195's Admission record, the admission record indicated an admitted [DATE] with the diagnosis including paranoid schizophrenia (a serious mental disorder in which people interpret reality abnormally with feelings of distrust and suspicion of other people). During a review of Resident 195's MDS dated [DATE], the MDS indicated Resident 195's cognition was severely impaired. During a review of Resident 195's Task flowsheet for the month of 12/2023 and 1/2024, for monitoring the resident's location every two hours, the flowsheet indicated: a. On 12/30/2023 and 1/1/2024, there was no documented monitoring completed for the day (7a.m.-3 p.m.), evening (3 p.m.- 11 p.m.), and night (11 p.m.-7 a.m.) shift. b. On 12/29/2023, 12/31/2023, 1/2/2024, 1/5/2024, and 1/9/2024 there was no documented monitoring completed on the night shift. c. On 12/27/2023, 12/28/2023, 1/3/2024 and 1/4/2024, there was no documented monitoring completed on the evening and night shift. During an interview on 1/10/2024 at 11:41 a.m. with the Director of Nursing (DON), the DON stated there should have been a note regarding the note clarification for Resident 74. The DON stated failing to properly document the note clarification provided an inaccurate status of the Resident 74's skin diagnosis. The DON stated The task flowsheet for Resident 195 had a lot of missing documentation. The DON stated Resident 195's location should be documented every two hours to monitor Resident 195's location and prevent any accidents. The DON stated if the monitoring was not documented, it cannot be guaranteed that it was completed. The DON stated documentation was the only thing that supports the care was provided. During a review of facility's policy titled Charting and Documentation dated 12/2022, the policy indicated any notable changes in the resident's medical and physical condition observed by staff, should be documented in the resident's medical record. The policy indicated the medical record facilitates communication between the interdisciplinary team.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on observation, interview and record review, the facility failed to assess mental capacity (ability to make decisions) and provide information to one of three sampled residents (Resident 216) before signing arbitration agreement. This failure had the potential to result in Resident 216 not fully understanding his right to limit opportunity to initiate judicial proceedings that challenge unfavorable decisions. Findings: During a review of Resident 216's admission record, the admission record indicated Resident 216 was admitted to the facility on [DATE]. Resident 216's diagnosis included schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), aneurysm (part of an artery wall weakens, allowing it to abnormally balloon out or widen) bipolar disorder(brain disorders that causes changes in a person's mood, energy, and ability to function), neurocognitive disorder (decreased mental function due to a medical disease other than a psychiatric illness), and personality disorder (a mental health condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems). During a review of Resident 216's History and Physical (H&P), dated 5/25/2023, the H&P indicated, Resident 216 had no capacity to understand and make decisions. During a review of Resident 216's Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 11/29/2023, the MDS indicated Resident 216 required maximal assistance (helper does more the half the effort) from one staff for shower, moderate assistance (helper does less than half the effort) from one staff for dressing, personal hygiene, set up help for eating. During a review of Resident 216's Arbitration Agreement (AA), dated 6/20/2023, the AA indicated, Resident 216 signed the arbitration agreement on 6/20/2023. The AA indicated, there was no signature of Resident 216's authorized agent. During a concurrent observation and interview on 1/9/2024, at 10:28 a.m., with Resident 216 in the outside patio, Resident 216 was walking back and forth. Resident 216 was oriented to person and to self. Resident 216 stated, he did not know where he was and why he was at the facility. Resident 216 stated, he did not know where his room located and that was why he was walking around. During an interview on 1/10/2024, at 9:32 a.m., with Admission Coordinator (AC), AC stated, she believed Resident 216 was able to understand what she explained about arbitration agreement. AC stated, she determined that Resident 216 was able to sign for himself because he was able to repeat back whatever she explained to him. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/10/2024, at 10:10 a.m., with Resident 216's Family Member (FM) 1 via phone, FM1 stated, she was not aware of the arbitration agreement. FM 1 stated, she got very upset, because the facility tried to take an advantage of the resident because she lives in Nevada. FM 1 stated, Resident 216 did not have any capacity to understand what he was told to sign. FM 1 stated, she would definitely take action regarding this fraudulent agreement. During an interview on 1/10/2024, at 10:30 a.m., with AC, AC stated, she should have contacted FM1 even though Resident 216 seemed fine upon admission because majority of residents had mental illness with limited mental capacity. AC stated, she should have confirmed with H&P or nursing staff. During an interview on 1/10/2024, at 11:00 a.m., with Administrator (ADM), ADM stated, the facility should have determined the resident's mental capacity with H&P and made sure the resident or responsible party fully understood regarding arbitration agreement. ADM stated full disclosure of arbitration agreement was important because this might limit the residents' opportunities to pursue legal process or action against the facility by signing the arbitration agreement. During a review of the facility's policy and procedure (P&P) titled, Binding Arbitration Agreements, dated 11/2023, the P&P indicated Residents (or their representatives) have the right to make informed decisions about important aspects of their health, welfare and safety . 5. The terms and conditions of a binding arbitration agreement are explained to the resident (or representative) in a way that ensures his or her understanding of the agreement, including that the resident may be giving up his or her right to have a dispute decided in a court proceeding . 7.After the terms and conditions of the agreement are explained, the resident or representative must acknowledge that he or she understands the agreement before being asked to sign the document. a. A signature alone is not sufficient acknowledgement of understanding. b. The resident (or representative) must verbally acknowledge understanding, and the verbal acknowledgement documented by the staff member who explains the agreement.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on observation, interview, and record review, the facility failed to observe infection control measures for 2 of 233 residents in the facility by failing to: 1.Ensure One out of one laundry aide perform hand hygiene after removing used gloves when handling clean linens. This deficient practice had the potential to cause contamination of clean linens and place residents of the facility at risk for infection. 2. Ensure staff wash hands after taking soiled gloves off. This deficient practice had the potential to transmit infectious microorganisms and increase the risk of infection for the resident population throughout the facility. Findings: 1.During an observation on 1/11/2024 at 08:49 AM in the facility's laundry room, the laundry aide removed her gloves and gown and went to unload clean laundry and fold linens without performing hand hygiene. During an interview on 1/11/2024 at 09:10 AM, the laundry aide stated that hand hygiene should be performed in between handling dirty to clean laundry and when removing personal protective equipment ([PPE]- equipment worn to minimize exposure to hazards that can cause illness). 2.During a review of Resident 38's admission record , the admission record indicated Resident 38 was admitted to the facility on [DATE] with diagnoses of cerebral ischemia (an acute brain injury that results from impaired blood flow to the brain), hyperlipidemia (elevated level of unhelathy fats in the blood) and depression (a condition that negatively affects feelings, thoughts and actions). During a review of Resident 38's history and physical (H&P) report dated 3/30/2023, the H&P indicated resident 38 had no capacity to make decisions. During a review of Resident 38's Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 12/29/2023, the MDS indicated Resident 38 required supervision or touching assistance (helper provides verbal cues and or /touching/ steadying and/ or contact guard assistance as resident completes activity) to sit, to stand, lying to sitting on side of bed and eating. During an observation on 1/8/2024 at 12:15 a.m., in the hallway, Licensed Vocational Nurse 8 (LVN) 8 exited from Resident 38's room wearing soiled gloves she walked to the medication cart disposed of the gloves in the trashcan on her cart then proceeded to chart . During an interview on 1/8/2024 at 12:45 p.m., LVN 8 stated she forgot to take off the gloves before exiting the room and that when taking off gloves and disposing them you must wash your hands after. LVN 8 stated it was important to wash your hands for infection control and you can germs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/8/2024 at 3:45 p.m., Unit Manager (UM) stated it important to wash hands before putting on gloves and after taking gloves off to prevent infection. During an interview on 1/12/2024 at 08:46 a.m., with the Director of Nursing (DON), the DON stated the correct way of hand hygiene is to clean hands before putting on gloves and to clean hands when taking them off, gel in gel out to prevent the spread of infection from Resident to Resident. During a review of the facility's policy and procedure (P/P) titled Hand Washing/ Hand Hygiene Revised 10/2023, the P/P indicated hand hygiene is indicated : 1.Immediately before touching a resident. 2.After touching a resident. 3.After touching the resident's environment . 4.Immediately after glove removal. 45777 49131

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on observation, interview, and record review the facility failed to ensure 45 of 95 resident rooms met the requirements of 80 square feet ([sq. ft.] a unit of area measurement) per residents in multi-bed resident rooms and 100 sq. ft for each single bed resident room. This deficient practice had the potential to result in an inadequate provision of safe nursing care, and privacy for the residents. Findings: During a review of the facility's Client Accommodations Analysis form, provided by the facility on 1/8/2024, the facility had 43 rooms that measured less than 80 sq. ft. per resident in multi-bed rooms and two rooms that measured less than 100 sq. ft for a single bedroom. The resident rooms were as follow: Palm Grove Unit; Room G1 (3 beds) 223.53 sq. ft. Room G2 (3 beds) 223.53 sq. ft. Room G3 (3 beds) 223.53 sq. ft. Room G4 (3 beds) 223.53 sq. ft. Room G5 (3 beds) 223.53 sq. ft. Room G6 (3 beds) 223.53 sq. ft. Room G7 (3 beds) 223.53 sq. ft. Room G8 (3 beds) 223.53 sq. ft. Room G9 (3 beds) 223.53 sq. ft. Room G10 (3 beds) 223.53 sq. ft. Room G11 (3 beds) 223.53 sq. ft. Room G12 (3 beds) 223.53 sq. ft. Room G13 (3 beds) 223.53 sq. ft. Room G14 (3 beds) 223.53 sq. ft. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Room G15 (3 beds) 223.53 sq. ft. Room G16 (3 beds) 223.53 sq. ft. Room G17 (3 beds) 223.53 sq. ft. Room G18 (3 beds) 223.53 sq. ft. Room G19 (3 beds) 223.53 sq. ft. Room G20 (3 beds) 223.53 sq. ft. Room G21 (3 beds) 223.53 sq. ft. Room G22 (3 beds) 223.53 sq. ft. Room G23 (3 beds) 223.53 sq. ft. Room G24 (3 beds) 223.53 sq. ft. Palm [NAME] East Unit; Room T1 (4 beds) 297.5 sq. ft. Room T3 (4 beds) 296.66 sq. ft. Room T5 (4 beds) 296.66 sq. ft. Room T6 (4 beds) 296.66 sq. ft. Room T8 (4 beds) 296.66 sq. ft. Room T10 (5 beds) 296.66 sq. ft. Room T12 (4 beds) 296.66 sq. ft. Room T14 (4 beds) 296.66 sq. ft. Room T15 (4 beds) 296.66 sq. ft. Room T17 (4 beds) 296.66 sq. ft. Room T18 (4 beds) 296.66 sq. ft. Room T20 (4 beds) 296.66 sq. ft. Palm [NAME] Unit; (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Room T21 (4 beds) 296.66 sq. ft. Room T23 (4 beds) 296.66 sq. ft. Room T27 (4 beds) 296.66 sq. ft. Room T29 (4 beds) 296.66 sq. ft. Room T30 (4 beds) 296.66 sq. ft. Room T32 (4 beds) 296.66 sq. ft. Room T34 (4 beds) 296.66 sq. ft. Palm Villa Unit; Room V1 (1 beds) 93.265 sq. ft. Room V20 (1 beds) 93.265 sq. ft. During an interview on 1/11/2024 at 4:31 p.m., with the Administrator (ADM), ADM stated he was aware of the recommendation of 80 sq. ft. per resident in multiple resident rooms and 100 sq. ft. for residents in a single resident room. ADM stated the regulation specify room sq. ft to ensure resident have a home-like environment, was treated with dignity, and to alleviate any safety concerns. The ADM stated he requested a room waiver. During observations, from 1/8/2024 through 1/12/2024, the residents residing in these rooms had enough space to move freely inside the rooms. Each resident in the above rooms had beds and side tables with drawers. There was adequate room for the operation and use of wheelchairs, walkers, or canes. Resident room size did not affect the nursing care or privacy provided to the residents. During a review of the facility's policy and procedure (P&P) titled, Bedrooms, revised 5/2017, the P&P indicated, Policy Interpretation and Implementation: 1. Bedrooms accommodate no more than two residents at a time. 2. Bedrooms measure at least 80 square feet of space per resident in double rooms, and at least 100 square feet of space in single rooms. 3. Each room is designed to provide full visual privacy for each resident and equipped for adequate nursing care.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on observation, interview and record review, the facility failed to ensure one of one resident's (Resident 141) call light was functional and accessible when Resident 141 needed to call for assistance to be repositioned to eat lunch. This deficient practice resulted in Resident 141 unable to call for assistance and had the potential for Resident 141's needs to go unmet. Findings: During a review of Resident 141's Admission Record, the Admission Record indicated Resident 141 was admitted on [DATE] with the diagnosis including paranoid schizophrenia (a serious mental disorder in which people interpret reality abnormally with feelings of distrust and suspicion of other people). During a review of Resident 141's Minimum Data Set ([MDS- a standardized assessment and are screening tool) dated 1/5/2024, the MDS indicated Resident 141's cognition (thinking and reasoning) was severely impaired. The MDS indicated Resident 141 requires supervision or steadying when changing positions from lying to sitting on the side of the bed. During a record review of Resident 141's care planned focused on self-care deficits, revised on 1/19/2023, the care plan indicated an intervention of ensuring the call light is within reach and to respond promptly to all requests for assistance. During an observation on 1/8/2024 at 1:40 p.m. of Resident 141's call light system in Resident 141's room, the call light string was observed to be broken and short. The call light system was not within reach of Resident 141 as Resident 141 was lying in her bed. Resident 141 could not find the string for the call light system. During an interview on 1/8/2024 at 1:40p.m. with Resident 141, Resident 141 stated she wanted to sit up so she can eat lunch and she couldn't call for help without a call light. During an interview on 1/8/2024 at 1:42 p.m. with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated Resident 141's call light was broken, recently snapped off and was not sure if maintenance was notified regarding the call light string. CNA 6 stated Resident 141's call light should be within reach because the resident might need to be changed, need water, or they could have fallen and need assistance. During a concurrent record review of the maintenance log and interview on 1/8/2024 at 1:42 p.m. with CNA 6, the maintenance log was reviewed. The log indicated no report that Resident 141's call light was broken and needed repair. CNA 6 stated there was no report of the broken string on Resident 141's call light. CNA 6 stated the call light should be reported immediately. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/11/2024 at 1:56 p.m. with the Director of Nursing (DON), the DON stated the call light should be in working order so the staff can be alerted when the resident needs assistance. The DON stated broken call lights should be reported through the maintenance log and phone group chats. The DON stated if the call light was not working properly there was the potential for the resident's needs to go unmet and possible neglect of the resident's needs. During a review of the facility's policy titled Answering the Call Light dated 2001, the policy indicated the staff should ensure the call light is always plugged in. The policy indicated when the resident was in the bed the call light should be within easy reach of the resident. The policy indicated the staff should be reporting all defective call lights to the nurse supervisor promptly.