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	07/12/2024

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** 46415 Based on observation, interview, and record review, the facility failed to obtain informed consent from Resident 209's responsible party prior to administering psychotropic medications for one of two sampled residents (Resident 209). This deficient practice had the potential to affect Resident 209's rights and self-worth. During a review of Resident 209's Admission Record, the Admission Record indicated Resident 209 was initially admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia (a mental illness that causes seeing, feeling and hearing things that are not based on reality), atrial fibrillation (irregular heart rhythm), major depressive disorder (prolonged feelings of sadness and loss of interest in activities of daily living), and anxiety disorder (excessively worrying or fearing about everyday situations). During a review or Resident 209's MDS dated [DATE], the MDS indicated Resident 209's cognitive skills were moderately impaired. The MDS indicated Resident 209 did not exhibit behavioral symptoms such as screaming, hitting, hallucinating (hear, see, feel things that appear to be real but exists only in the mind), and expressed feeling down, tired, moving or speaking slowly, trouble falling asleep more than half of the days. During a review of Resident 209's history and physical (H&P) note dated 1/25/2024, the H&P indicated Resident 209 was alert and oriented to self and unable to make his/her own medical decisions at this time. During a review of the Informed Consent form for psychoactive medication (medication that affects perception and consciousness) dated 1/25/2024, the informed consent indicated Resident 209 was the one who was informed of the risks and benefits and consented to receiving Mirtazapine (antidepressant medication) 15 milligram (mg: unit of mass or weight) oral tablet at bed time by mouth and Olanzapine (medication used to treat schizophrenia) oral tablet 5 mg every night. During a review of the Order Summary Report (Physician's Order), the order summary report indicated Olanzapine oral tablet 5mg one tablet by mouth in the evening for paranoid schizophrenia manifested by mood swing. Inform consent obtained by Psychiatrist 1 (PSY1) from resident with a start date of 1/26/2024. (continued on next page)

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 7/12/2024 at 9:08 am with the Primary Physician (PP), the PP stated Resident 209 had a history of schizophrenia at admission in January and currently Resident 209 was not able to make decisions for herself. During a concurrent interview and record review on 7/12/2024 at 11:55 am, with Registered Nurse 2 (RN 2), RN 2 stated for psychotropic medications, the facility process is to obtain the order from the physician, verify the informed consent is obtained from Resident or responsible party to ensure risk and benefits of taking the medications were explained to them. RN 2 stated based on the history and physical examination on 1/28/2024, Resident 209 was unable to make decisions for herself. RN 2 stated for any medication decisions, a consent would be required, and the responsible party will be contacted while respecting residents rights. RN 2 stated giving a resident that cannot make decisions for themselves without calling the responsible party is not a good practice since consent is everything. During a review of the facility's P&P titled Decision Making Capacity created on April 2024, the P&P indicated the physician is required to interview the resident, review the medical records, and consult with other sources of information as available and appropriate (e.g., family members, staff and/or other involved persons). If a resident had no surrogate decision maker and lacks capacity, the IDT will contact the Office of the Long-Term Care Patient Representative to assist with making decisions related to the risks and benefits of the proposed medical intervention (e.g., treatment, change in medication, diagnostic procedure, etc.). The physician (or licensed mental health provider -Psychiatrist, Psychologist) will determine the resident's capacity to consent to medical care upon admission. It a licensed mental health provider determines the resident's capacity, the primary physician must be informed of this determination, and must document the capacity determination on the physician's order sheet. During a review of the facility's P&P titled Psychoactive/Psychotropic Medication Use undated, the P&P indicated the prescribing clinician will obtain informed consent from the resident (or, as appropriate, the resident representative) for use of a psychotropic medication .prior to prescribing a psychotropic medication, the prescribing clinician must personally examine the resident.

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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** 46537 Based on interview and record review, the facility failed to ensure Advance Directives ([AD]-written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) were discussed and written information was provided to the residents and/or responsible parties and had a completed 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) for three of eight sampled residents (Resident 151, Resident 191, and Resident 170) 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: During a review of Resident 151's Admission Record, the Admission Record indicated, Resident 151 was initially admitted to the facility on [DATE] and last re-admission was on [DATE] with diagnoses including cerebral infarction (a loss of blood flow to part of the brain), schizoaffective disorder (a serious mental illness that affects how a person thinks, feels, and behaves), end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis) on hemodialysis (a machine filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and alcohol dependence. During a review of Resident 151's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 151 did not have the capacity to understand and make decisions. During a review of Resident 151's Minimum Data Set ([MDS]-a standardized assessment and care screening tool), dated [DATE], the MDS indicated Resident 151 required maximal assistance (Helper does more than half the effort) from one staff for oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, sit to stand, chair/bed to chair transfer, toilet transfer, moderate assistance (Helper does less than half the effort) from one staff for rolling left and right, sit to lying, lying to sitting on side of bed, and supervision or touching assistance (helper provides verbal cues and /or touching/contact guard assistance) from one staff for eating. During a review of Resident 151's Order Summary Report (OSR), dated [DATE], the OSR indicated, a physician's order dated [DATE] that Resident 151 was incapable of understanding Rights, Responsibilities, and giving Informed Consent. (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 concurrent interview and record review on [DATE], at 11:22 am., with Licensed Vocational Nurse (LVN) 5, Resident 151's Physician Orders for Life-Sustaining Treatment (POLST), dated [DATE] was reviewed. The POLST indicated, Resident 151 was Do not attempt Resuscitation ([DNR]-allow natural death) status. The POLST indicated, physician's license number on section D (Information and Signature) was left blank. The POLST indicated, Resident 151 signed on section D. The POLST did not indicate, the preparer's name, title, and phone number. LVN 5 stated, the POLST was not completed because there was missing information and Resident 151 had no capacity to make decision or sign the documentation. LVN 5 stated, if the POLST was not completed, the resident would be treated as full code and all life sustaining measures would be done during the emergency per policy. LVN 5 stated, the resident would be treated against his/her wishes due to the form being incomplete During a concurrent interview and record review on [DATE], at 3:08 pm, with the Social Service Director (SSD), Advance Directive Acknowledgement (ADA), dated [DATE] was reviewed. The ADA indicated, Resident 151 signed the ADA form on [DATE].The SSD stated, Resident 151 initialed and signed the ADA form, but he was not sure the resident fully understood what he was signing regarding the ADA. The SSD stated, the resident was referred to conservatorship (a court appoints a person to manage the financial and personal affairs of a minor or incapacitated person). During a review of Resident 191's Admission Record, the Admission Record indicated, Resident 191 was initially admitted to the facility on [DATE] and last re-admission was on [DATE] with diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), epilepsy (a brain disorder that causes recurring, unprovoked a sudden, uncontrolled burst of electrical activity in the brain), and paranoid schizophrenia (a mental illness that causes a break from realty with beliefs that usually involve persecution). During a review of Resident 191's H&P dated [DATE], the H&P indicated, Resident 191 had fluctuating capacity to understand and make decisions. During a review of Resident 191's MDS dated [DATE], the MDS indicated Resident 191 required maximal assistance from one staff for oral hygiene, toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, personal hygiene, chair/bed to chair transfer, toilet transfer, moderate assistance from one staff for upper body dressing, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, and supervision or touching assistance (helper provides verbal cues and /or touching/contact guard assistance) from one staff for eating. During a review of Resident 191's OSR, dated [DATE], the OSR indicated a physician's order dated [DATE], Resident 191 is incapable of understanding Rights, Responsibilities, and Informed Consent. During a review of Resident 191's Care Plan (CP), initiated on [DATE], the CP Focus indicated, Resident 191 had a POLST for DNR Status. The CP Interventions indicated, the DNR POLST form will be in the medical records at all times. Staff will recognize resident wishes and follow as indicated. (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 concurrent interview and record review on [DATE], at 3:27 p.m., with the SSD, Resident 191's POLST, dated [DATE] was reviewed. The POLST indicated, Resident 191 was DNR. The POLST did not indicate, the physician's license number and phone number. The POLST indicated, verbal/telephone consent from the responsible party (RP) on with one witness signature. The POLST did not indicate, the preparer's name, title, and phone number. The SSD stated, the POLST was not completed because there was missing information. The SSD stated, if the POLST was not completed, the resident would be treated as a full code and all life sustaining measures would be done during an emergency, per facility policy. The SSD stated that if the Resident wished to be DNR and life sustaining measures were done, that would be against the resident's wish. The SSD stated, the POLST and AD should be offered upon admission and quarterly at least and should be audited by medical record staff for completion. The SSD stated, there should be two witness signatures when obtaining a verbal or telephone consent. During a review of Resident 170's Admission Record, the Admission Record indicated, Resident 170 was initially admitted to the facility on [DATE] and last re-admission was on [DATE] with diagnoses including epilepsy, schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and cognitive communication deficit (someone has trouble with one or more cognitive processes involved in communication). During a review of Resident 170's H&P, dated [DATE], the H&P indicated, Resident170 had the capacity to understand and make decisions. During a review of Resident 170's MD, dated [DATE], the MDS indicated Resident 170 required supervision or touching assistance from one staff for oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, sit to stand, chair/bed to chair transfer, toilet transfer, rolling left and right, sit to lying, lying to sitting on side of bed, and set up or clean-up assistance (Helper sets up or cleans up. Resident completes activity) from one staff for eating. During a review of Resident 170's Psychiatric Follow- up Note (PFN), dated [DATE], the PFN indicated, Resident170 had impaired insight and judgement and significant impaired coping skills. During a review of Resident 170's Social Service Note (SSV), dated [DATE], the SSV indicated, that Resident 170 did not have an advance directive on file. The SSV indicated Resident 170 did not have the capacity to formulate an advance directive, During a review of Resident 170's CP, initiated [DATE], the CP Focus indicated, Resident 170 had impaired cognitive function or impaired thought processes related to difficulty making decisions. The CP Interventions indicated, to communicate with resident regarding capabilities and needs. During a review of Resident 170's OSR, dated [DATE], the OSR indicated a Physician's Order dated [DATE] that Resident 170 was incapable of understanding Rights, Responsibilities, and Informed Consent that was ordered on [DATE]. (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 concurrent interview and record review on [DATE], at 3:39 p.m., with the SSD, Resident 170's POLST, dated [DATE] was reviewed. The POLST indicated, Resident 170 was a DNR. The POLST did not indicate the physician's license number, name, and phone number. The POLST indicated, Resident 170 signed the form. The SSD stated, the POLST was not completed because there was missing information. The SSD stated, the POLST was outdated and was not completed. The SSD stated, there was conflicting information regarding the resident's mental capacity. The SSD stated, there was no AD documented and he could not provide evidence that AD was offered to the resident or RP. The SSD stated, he was working on public guardianship (The Public Guardian is responsible for the care of individuals who are no longer able to make decisions or care for themselves). During an interview on [DATE], at 9:10 a.m., the Interim Director of Nursing (IDON) stated, the POLST provided guidelines for treatment during emergency such as code blue (a hospital code used to indicate a patient requiring immediate resuscitation). The IDON stated, the status of the AD should be discussed during Interdisciplinary Team ([IDT]- the resident's healthcare team that assess, coordinate, and manage each resident's comprehensive health care, including his or her medical, psychological, social, and functional needs) meeting and offered to the residents and RP. During a review of facility's policy and procedure (P&P) titled, Advance Directives, revised ,d+[DATE], 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: Determining Existence of Advance Directive .2. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 3. Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or representative .5.If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative . Decision-Making Capacity: 1. Upon admission the interdisciplinary team assesses the residents decision-making capacity and identifies the primary decision-maker if the resident is determined not to have decision-making capacity .If the Resident Does not have an Advance Directive: 1. If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives .b. Nursing staff will document in the medical record the offer to assist and the residents decision to accept or decline assistance. 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 .Refusing or Requesting Treatment: 1.The resident has the right to refuse medical or surgical treatment, whether or not he or she has an advance directive. a.A resident will not be treated against his or her own wishes. (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 facility's P&P titled, Do Not Resuscitate Order, revised ,d+[DATE], the P&P indicated, Policy Statement: Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect. Policy Interpretation and Implementation: 1. Do not resuscitate orders must be signed by the resident's attending physician on the physician's order sheet maintained in the resident's medical record. 2. A Do Not Resuscitate (DNR) order form must be completed and signed by the attending physician and resident (or resident's legal surrogate, as permitted by state law) and placed in the front of the resident's medical record. 3.In addition to the advance directive and DNR order form, state-specific forms may be used to specify whether to administer CPR in case of a medical emergency. State-specific forms include: a. Physician Orders for Life-Sustaining Treatment (POLST) . 4. Should the resident be transferred to the hospital, a photocopy of the DNR order form must be provided to the personnel transporting the resident to the hospital. 5. Do not resuscitate (DNR) orders will remain in effect until the resident (or legal surrogate) provides the facility with a signed and dated request to end the DNR order. a. Verbal orders to cease the DNR will be permitted when two (2) staff members witness such request . 6. The interdisciplinary care planning team will review advance directives with the resident during quarterly care planning sessions to determine if the resident wishes to make changes in such directives. 7. The resident's attending physician will clarify and present any relevant medical issues and decisions to the resident or legal representative as the resident's condition changes in an effort to clarify and adhere to the resident's wishes.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview and record review, the facility staff failed to ensure one of six sampled residents (Resident 143) was free from an unnecessary physical restraint, as evidenced by: 1.Failing to ensure appropriate assessment for less restrictive measures prior to using a physical restraint for Residents 143. 2.Failing to obtain a physician order for the use of bilateral bolsters (a pillow shaped like a long tube which is put across the bed) used as a physical restraint for Resident 143. 3.Failing to follow facility's Policy and Procedure (P&P) for use of restraints. Findings: During an observation on 7/8/2024 at 2:47 p.m., in Resident 143's room, Resident 143 was observed lying in bed supine (on the back) position. Resident 143's bed was placed in low position with bilateral (both sides) bolsters. During a review of Resident 143's Admission Record, the Admission Record indicated Resident 143 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a loss of brain function such as memory, thinking, language, behavior), anxiety (a feeling of worry or fear), hypertension (high blood pressure), dysphagia (difficulty swallowing), and muscle weakness (loss of muscle strength). During a review of Resident 143's Minimum Data Set ([MDS] - a comprehensive standardized assessment and care-screening tool), dated 5/23/2024, the MDS indicated Resident makes self-understood and understands others. The MDS indicated Resident 32 was dependent (helper does all the effort) from staff for toileting hygiene, shower, oral hygiene, and personal hygiene. During a review of Resident 143's History and Physical (H&P), dated 12/2/2023, the H&P indicated Resident 143 was alert and oriented to self. The H&P indicated Resident 143 was unable to make medical decisions. During a concurrent observation and interview on 7/9/2024 at 12:47 p.m., in Resident 143's room, with LVN 3, Resident 143 was lying in bed, and Resident 143's bed was placed in low position with bilateral bolsters. LVN 3 stated the facility placed Resident 143's bed in low position, and bilateral bolsters to prevent Resident143 from getting out of bed unassisted and to prevent Resident 143 from falling and having an injury. LVN3 stated Resident 143 was at risk for falls. LVN3 stated Resident 143 was not able to remove bilateral bolsters without facility staff assistance. During a concurrent interview and record review on 7/10/2024 at 11:22 a.m., with LVN 3, Resident 143's Electronic Medical Record (EMR) was reviewed. LVN 3 stated there was no documentation that less restrictive measures were implemented to keep Resident 143 from falling prior to placing bilateral bolsters. LVN 3 stated there was not a physician order for the use of restraints for Resident 143. (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 P&P titled, Use of Restraints, revised 4/2017, the P&P indicated 1.Restraints should be used for safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. 2.Restraints shall be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. 3.When the use of restraints in indicated, the least restrictive will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. 4.Physical Restraints are defined as any manual method or physical or mechanical device. If the resident cannot remove a device in the same manner in which the staff applied if given that resident's physical condition, and this restricts his/her typical ability to change position or place, that device is considered a restraint. 5.Practices that inappropriately utilize equipment to prevent mobility are considered restraints and are not permitted.

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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** 36943 Based on observation, interview, and record review, the facility failed to 1.Report an injury of unknown source resulting in serious bodily injury and complete the investigation for one of nine sampled residents (Resident 73) with limited range of motion [ROM, full movement potential of a joint (where two bones meet)] and mobility (ability to move). On 5/8/2024, Resident 73's X-ray (image that creates pictures of the inside of the body) results indicated Resident 73 had a left displaced (bone moved out of its original position) femoral neck (narrow portion of the hip bone) fracture (break in the bone). 2. To report to the appropriate State Agencies, including the Department of Public Health and the local Ombudsman (representatives assist residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences), within two hours and failed to complete the investigation into the cause of Resident 73's left hip fracture in accordance with the facility's policy titled, Abuse Prevention. The facility's failure to report Resident 73's left hip fracture of unknown source resulted in delayed State Agency investigation regarding the circumstances of Resident 73's injury. This deficient practice placed Resident 73, including residents with severely impaired cognition (ability to think, understand, learn, and remember), to be at-risk for abuse, neglect, or mistreatment. Findings: During a review of Resident 73's Admission Record, the Admission Record indicated the facility admitted Resident 73 on 10/26/2022 and readmitted on [DATE] with diagnoses including dementia (decline in mental ability severe enough to interfere with daily life), major depressive disorder (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily functioning), muscle weakness, and left displaced femoral neck fracture. During a review of Resident 73's Minimum Data Set ([MDS] a comprehensive assessment and care planning tool), dated 1/30/2024, the MDS indicated Resident 73 had clear speech, expressed ideas and wants, clearly understood verbal content, and had severely impaired cognition. The MDS indicated Resident 73 was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for eating, oral hygiene (ability to use suitable items to clean teeth), toileting, showering/bathing, lower body dressing, and chair/bed-to-chair transfers. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 73's Rehab - Joint Mobility Screen (brief assessment of a resident's ROM in both arms and both legs), dated 1/30/2024, the Joint Mobility Screen indicated Resident 73's ROM in both shoulders, elbows, wrists, and hands were within functional limits ([WFL] sufficient movement without significant limitation). The Joint Mobility Screen indicated Resident 73 had ROM impairments in both legs, including severe ROM limitations (25 percent [%] or less of full ROM) in the left hip, both knees, and both ankles, and moderate ROM limitation (approximately 50% of full ROM) in the right hip. The Joint Mobility Screen indicated Resident 73 was receiving Restorative Nursing Aide (RNA, certified nursing aide program that helps residents to maintain their function and joint mobility) for passive range of motion (PROM, movement of joint through the ROM with no effort from the person) exercises to both arms and both legs, five times per week, but was noted to have stiffness in both hips, knees, and the right ankle. During a review of Resident 73's Rehab - Screening Form (brief assessment of a resident's abilities), dated 1/30/2024, the Rehab -Screening Form indicated the nursing staff, including the RNA, indicated Resident 73 had a change that required therapy intervention. The Rehab - Screening Form indicated Resident 73 refused to participate in RNA and would benefit from a Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation. During a review of Resident 73's Change in Condition ([CIC] major decline or improvement that affects a resident's health or will not resolve without intervention) Evaluation, dated 2/1/2024, the CIC Evaluation indicated Resident 73 declined to participate in the RNA program. The CIC Evaluation indicated Resident 73's physician was notified and ordered a PT and Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluation. Resident 73's CIC Evaluation also indicated Family Member 1 (FM 1) was notified. During a review of Resident 73's PT Evaluation and Plan of Treatment, dated 2/2/2024, the PT Evaluation indicated Resident 73 was referred to PT due to a decline in functional mobility and refusals with the RNA program. The PT Evaluation indicated Resident 73's ROM in both hips and both knees were impaired, including left hip flexion (bending the leg at the hip joint toward the body) 0 to 30 degrees (0-30 degrees, normal 0-120 degrees), right hip flexion 0-60 degrees, left knee flexion (bending the knee) 0-30 degrees (normal 0-135 degrees), and right knee flexion 0-60 degrees. The PT Evaluation indicated Resident 73 laid supine (back on bed) with the right leg positioned on top of the left leg with noted stiffness to both legs. The PT Evaluation indicated Resident 73 had limited tolerance for supported sitting with the head-of-bed elevated and refused to sit up at the edge of the bed. The PT Plan of Treatment included therapeutic exercises (movement prescribed to correct impairments and restore muscle function), neuromuscular reeducation (technique used to restore movement patterns through repetitive motion to retrain the brain), and therapeutic activities (tasks that improve the ability to perform activities of daily living {[ADLs] tasks related to personal care including bathing, dressing, hygiene, eating, and mobility}), four times per week for four weeks. During a review of the PT Treatment Encounter Note, dated 2/6/2024, the PT Treatment Encounter Note indicated Resident 73 initially laid supine in bed, confused with non-sensical (phrases that do not make sense) speech, and did not have any pain. The PT Treatment Encounter Note indicated Resident 73 was sad and suddenly angry throughout the treatment and allowed PROM exercises of both legs and gentle stretching of the joints. The PT Treatment Encounter Note indicated Resident 73 was very resistive to sitting up at the edge of the bed and preferred lying down in bed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 73's CIC Evaluation, dated 2/7/2024, the CIC Evaluation indicated Resident 73 had aggressiveness and combativeness (ready or eager to fight) behavior during care. The CIC Evaluation indicated Resident 73's psychiatrist was contacted and ordered one milligram (mg, unit of measure) of lorazepam (medication used to treat anxiety [apprehension, tension, or uneasiness that stems from the anticipation of danger]). Resident 73's CIC Evaluation also indicated FM 1 was notified. During a review of Resident 73's PT Discharge Summary, dated 3/8/2024, the PT Discharge Summary indicated Resident 73's ROM in both legs improved, including 0-45 degrees left hip flexion, 0-90 degrees right hip flexion, 0-45 degrees left knee flexion, and 0-90 degrees right knee flexion. Resident 73's PT Discharge Summary recommendations included RNA to perform PROM to both legs. During a review of Resident 73's Order Listing Report (report of physician orders) included physician orders, dated 3/11/2024,the Order Listing Report indicated for RNA to perform PROM to both legs as tolerated, five times per week, and application of an abductor pillow (cushion used to separate a person's legs) when supine in bed, five days per week. During a review of Resident 73's Rehab - Joint Mobility Screen, dated 4/30/2024, the Joint Mobility Screen, indicated Resident 73's ROM in both arms were WFLs but had ROM impairments in both legs, including severe ROM impairments in the left hip, left knee, and both ankles and minimal ROM impairments (approximately 75% of full ROM) in the right hip and right knee. The Joint Mobility Screen indicated Resident 73 had changes in left hip and left knee ROM, including tight adduction (hips moving toward the body) with feet crossing and difficulty separating the legs. The Joint Mobility Screen indicated a recommendation for a PT Evaluation. During a review of Resident 73's CIC Evaluation, dated 4/30/2024, the CIC Evaluation indicated Resident 73 was noted to have changes in ROM in the left hip and left knee, including tight adduction of both legs with feet crossing and difficulty separating the legs. The CIC Evaluation indicated Resident 73's physician was notified and ordered a PT Evaluation. Resident 73's CIC Evaluation also indicated FM 1 was notified. During a review of Resident 73's Interdisciplinary Team (IDT) Note, dated 5/2/2024, the IDT Note indicated Resident 73 was noted to have changes in ROM in the left hip and left knee during Resident 73's Joint Mobility Screen. The IDT Note indicated Resident 73 did not have any signs or symptoms of pain. The IDT Note indicated Resident 73's physician provided new orders for a PT Evaluation and a Physiatry (medical doctor who specializes in physical medicine and rehabilitation) evaluation for pain management. During a review of Resident 73's PT Evaluation and Plan of Treatment, dated 5/2/2024, the PT Evaluation indicated Resident 73 was referred to PT due to changes in ROM in the left hip and left knee. The PT Evaluation indicated Resident 73's ROM in both hips and both knees were impaired, including left hip flexion 0-15 degrees, right hip flexion 0-90 degrees, left knee flexion 0-20 degrees, and right knee flexion 0-90 degrees. The PT Evaluation indicated Resident 73 was in a supine position with the right leg positioned on top of the left leg, noted stiffness to the left leg more than the right leg, and decreased ROM to the left hip and knee. The PT Plan of Treatment included therapeutic exercises, neuromuscular reeducation, and therapeutic activities, four times per week for four weeks. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 73's Physical Medicine and Rehab note, dated 5/7/2024, the Physical Medicine and Rehab note indicated Resident 73 with noted limitations and difficulty with ROM in both legs, including the right leg fixed (immovable) in adduction. The Physical Medicine and Rehab physician (Physiatrist) recommendation included hip and knee X-rays due to difficulty performing ROM to Resident 73's both hips and both knees. During a review of Resident 73's physician orders, dated 5/7/2024, the physician orders indicated an X-ray of the hips one time only for one day. During a review of Resident 73's Radiology Results Report, dated 5/8/2024, the Radiology Results Report indicated Resident 73 had an age-indeterminate (unknown length of time), displaced left femoral neck fracture. During a review of Resident 73's Progress Note, dated 5/8/2024 at 7:20 p.m., the Progress Note indicated the nurse received a phone call from the X-ray company regarding Resident 73's abnormal X-ray result, received the X-ray report, and forwarded it to Resident 73's physician. During a review of Resident 73's CIC Evaluation, dated 5/8/2024 at 7:30 p.m., the CIC Evaluation indicated the facility received a phone call from the X-ray company regarding Resident 73's abnormal X-ray result which indicated an age-indeterminate, displaced left femoral neck fracture. The CIC Evaluation indicated Resident 73 was lying in bed, calm, denied any pain or discomfort, and did not have any facial grimacing (expression indicating pain). The CIC indicated Resident 73's physician was notified and ordered to administer Naproxen (medication that treats swelling and pain) 375 mg, every 12 hours as needed, an Orthopedic (branch of medicine dealing with the correction or prevention of deformities, disorders, or injuries of the bones and associated soft tissue) specialist referral, a Physiatrist consultation for pain management, and to apply the abduction pillow all times until Resident 73 received an Orthopedic specialist consultation. Resident 73's CIC Evaluation also indicated FM 1 was notified. During a review of Resident 73's Progress Note, dated 5/13/2024 (five days after receiving X-ray results on 5/8/2024), the Progress Note indicated Resident 73's physician assessed Resident 73 while in the facility and ordered for Resident 73 to be transferred to the General Acute Care Hospital (GACH) for evaluation due to left hip pain, tightness in both legs into adduction (the movement of a joint or body part inward toward the midline), and the abnormal X-ray with age-indeterminate displaced left femoral neck fracture. During a review of Resident 73's physician orders, dated 5/13/2024, the physician order indicated to transfer Resident 73 to the GACH emergency room for evaluation and treatment due to left hip pain, tightness in both legs into adduction, and abnormal X-ray with age-indeterminate displaced left femoral neck fracture. During a review of Resident 73's PT Discharge Summary, dated 5/14/2024, the PT Discharge Summary indicated Resident 73 was discharged from PT due to Resident 73's discharge to the hospital. During a review of Resident 73's Progress Note, dated 5/17/2024 at 5:17 p.m., the Progress Note indicated Resident 73 was readmitted to the facility with a diagnosis of an old left femoral fracture. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 73's MDS, dated [DATE], the MDS indicated Resident 73 was readmitted to the facility on [DATE]. The MDS indicated Resident 73 was dependent for eating, oral hygiene, toileting, showering/bathing, upper and lower body dressing, rolling to either side in bed, and chair/bed-to-chair transfers. During an observation and interview on 7/10/2024 at 9:40 a.m. with Resident 73 in the bedroom, Resident 73 was lying awake in bed, spoke words clearly but did not follow a clear conversation. Resident 73 did not have any pain and did not remember having a left hip fracture. During a concurrent observation and interview on 7/10/2024 at 11:40 a.m. with Occupational Therapist 1 (OT 1) in Resident 73's bedroom, Resident 73 was awake, alert, and sitting up in a gerichair (reclining chair that allows someone to get out of bed and sit comfortably in different positions while fully supported). Resident 73's right leg was crossed over the left leg. Resident 73 spoke words without logical conversation. OT 1 stood in front of Resident 73 and encouraged Resident 73 to perform arm exercises using one-pound (unit of measure) weights. OT 1 stated Resident 73 did not have understandable speech and required verbal and physical cues to focus on the exercises. During an interview on 7/10/2024 at 12:21 p.m. with Restorative Nursing Aide (RNA) 3, RNA 3 stated Resident 73 could speak but was very confused. RNA 3 stated Resident 73 started crossing the right leg over the left leg more than usual (unknown date). RNA 3 informed the nurse (unknown), who notified the therapy staff (unspecified), because Resident 73's position could affect Resident 7's care, including cleaning and toileting. RNA 3 stated Resident 73 received an X-ray but did not know the result. During a concurrent interview and record review on 7/10/2024 at 2:31 p.m. with OT 1, Resident 73's Rehab - Joint Mobility Screen, dated 1/30/2024 and completed by OT 1, was reviewed. OT 1 stated the RNA (unspecified) reported a decline in Resident 73's ROM during the weekly RNA meeting with the therapists. OT 1 stated Resident 73 had increased stiffness to both hips, knees, and ankles which were difficult to move. OT 1 stated a PT Evaluation was recommended for Resident 73. During a concurrent interview and record review on 7/10/2024 at 2:40 p.m. with Physical Therapist 1 (PT 1), Resident 73's PT Evaluation, dated 2/2/2024, and PT Discharge Summary, dated 3/8/2024, were reviewed. PT 1 stated Resident 73 was referred to PT due to refusing RNA exercises and for a decline in mobility, including refusing to get out of bed. PT 1 stated Resident 73's ROM during the PT Evaluation was limited in both legs, including the left hip 0-30 degrees, right hip 0-60 degrees, left knee 0-20 degrees, and right knee 0-60 degrees. PT 1 stated Resident 73 was discharged on [DATE] with improved ROM to left hip 0-45 degrees, right hip 0-90 degrees, left knee 0-45 degrees, and right knee 0-90 degrees. PT 1 recommended RNA to provide PROM on both legs and to apply an abductor pillow because Resident 73 had a habit of crossing the right leg over the left leg. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/10/2024 at 2:55 p.m. with PT 1, Resident 73's PT Evaluation, dated 5/2/2024, and PT Discharge Summary, dated 5/14/2024, were reviewed. PT 1 stated Resident 73 was referred back to PT after the Joint Mobility Screening, dated 4/30/2024, indicated a decline in left hip and left knee ROM. PT 1 stated Resident 73 had a decline in left hip and knee ROM during the PT Evaluation, including left hip 0-15 degrees (from 0-45 degrees) and left knee 0-20 degrees (from 0-45 degrees). PT 1 stated the facility found out Resident 73 had a left femoral neck fracture after receiving X-ray results on 5/8/2024. PT 1 stated not knowing the cause of Resident 73's left hip fracture since Resident 73 did not fall and did not complain of any pain. PT 1 stated Resident 73 was discharged from PT due to hospitalization on [DATE]. During an interview on 7/10/2024 at 3:08 p.m. with PT 1, PT 1 stated Resident 73 did not complain of pain during therapy. PT 1 stated Resident 73 had impaired cognition and would not remember how Resident 73 fractured the left hip. During a concurrent interview and record review on 7/10/2024 at 4:28 p.m. with the Assistant Director of Nursing (ADON), of Resident 73's Admission Record, Rehab - Joint Mobility Screen, dated 4/30/2024, IDT Notes, dated 5/2/2024, physician order for the X-ray, dated 5/7/2024, and X-ray results, dated 5/8/2024, were reviewed. The ADON stated Resident 73 was originally admitted to the facility on [DATE]. The ADON stated Resident 73 had a Joint Mobility Screen on 4/30/2024 which noted increased tightness in both legs but Resident 73 did not have any pain, discomfort, and facial grimacing. The ADON stated Resident 73's primary physician ordered a PT Evaluation and Physiatrist consultation, and the IDT met to discuss Resident 73's care. The ADON stated the Physiatrist recommended an X-ray due to Resident 73's leg stiffness and Resident 73's physician agreed to order the X-ray on 5/7/2024. The ADON stated the facility received the X-ray results on 5/8/2024 which indicated Resident 73 had an age-indeterminate displaced left femoral neck fracture. The ADON stated the facility did not know about Resident 73's fracture prior to the X-ray results on 5/8/2024. The ADON stated Resident 73 had impaired cognition and could not inform the facility how Resident 73 fractured the left hip. The ADON stated the left hip fracture had an unknown cause of injury. During an interview on 7/10/2024 at 5:18 p.m. with the Administrator (ADM), the ADM stated injuries of unknown source should be reported to the Department of Public Health within 24 hours. The ADM stated law enforcement and the Ombudsman should be notified if any abuse was suspected. During an interview on 7/10/2024 at 5:21 p.m. with the ADM, ADON, and Assistant Administrator (AADMIN), the AADMIN stated he was the Administrator when the facility received Resident 73's X-ray results on 5/8/2024, which indicated an age-indeterminate left hip fracture. The AADMIN stated Resident 73's left hip fracture was not reported to the Department of Public Health since it was age-indeterminate and was not a new injury. During a telephone interview on 7/10/2024 at 6:13 p.m. with FM 1, FM 1 stated Resident 73 did not have any history of hip fractures prior to residing in the facility. FM 1 stated Resident 73 started crossing one leg over the other in approximately 1/2024 (exact date unknown) and complained of pain whenever Resident 73's legs were uncrossed. FM 1 stated it made sense that Resident 73's X-ray results indicated a left hip fracture because Resident 73 had pain. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/12/2024 at 8:16 a.m. with the AADMIN, the AADMIN stated physical harm was any injury, including pain, bruising, and a fracture. The AADMIN stated the facility was required to report physical harm within two hours of knowing about the physical harm. The AADMIN stated if a resident (in general) had physical harm, then the facility would ensure the resident's safety, including sending the resident to the hospital, if necessary, report the physical harm to the Department of Public Health, Ombudsman, local law enforcement, and the resident's responsible party, and then the facility would investigate the incident. The AADMIN stated Resident 73's left hip fracture was physical harm with an unknown cause of injury and Resident 73's cognition disabled Resident 73 from explaining how the injury occurred. The AADMIN stated Resident 73's left hip fracture should have been reported within two hours. The AADMIN stated the facility started the investigation on 5/14/2024 (six days after receiving the X-ray results) but did not finish the investigation for Resident 73's left hip fracture of unknown cause. During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention, dated 12/31/2015, the P&P indicated the facility ensured the resident's rights were protected by providing a method for prevention, reporting and investigation of any type of alleged abuse. The P&P indicated staff will report injuries of unknown origin so that investigations can be conducted to rule out abuse and file all required documentation. The P&P indicated the facility was required to report all allegations of abuse, including injuries of unknown source, even if there was no reasonable suspicion of abuse within two hours. The P&P indicated the facility will perform an investigation, including interviewing employees, family, and visitors who may have knowledge of the alleged incident.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on observation, interview, and record review the facility failed to ensure the assessment entries on the Minimum Data Set (MDS- an assessment and care screening tool) were accurately documented for two of three sampled residents (Resident 194 and Resident 180) by: a. failing to reflect Resident 194's indwelling catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag) was removed and discontinued. b. failing to reflect Resident 180's pressure injury (the breakdown of skin integrity due to pressure) was reclassified (assigned to a different class or category) to skin ulcer (an open sore that develops when blood can't properly flow to an area of the body) by the wound care specialist. This failure had the potential to result in a negative effect on Resident 194 and Resident 180's plan of care and delivery of necessary services, care, and treatment. Findings: a. During a review of Resident 194's admission record, the admission record indicated Resident 194 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest),and urinary retention (a condition in which you are unable to empty all the urine from your bladder). During a review of Resident 194's History and Physical (H&P), dated 4/25/2024, the H&P indicated, Resident 194 did not have the capacity to understand and make decisions. During a review of Resident 194's Minimum Data Set ([MDS]-a standardized assessment and care screening tool), dated 6/10/2024, the MDS indicated Resident 194 required dependent assistance (Helper does all of the effort) from two or more staff for oral hygiene, toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, personal hygiene, sit to stand, chair/bed to char transfer, toilet transfer, tub/shower transfer, maximal assistance (Helper does more than half the effort) from one staff for upper body dressing, roll left and right, sit to lying, lying to sitting on side of bed, and supervision or touching assistance (Helper provides verbal cues and /or touching/steadying and /or contact guard assistances as resident completes activity) from one staff for eating. The MDS Section H (Bladder and Bowel) section indicated, Resident 194 had an indwelling catheter. During a review of Resident 194's Order Summary Report (OSR), dated 6/10/2024, the OSR indicated, Resident 194's indwelling catheter was discontinued on 10/16/2023. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/10/2024, at 11:35 a.m., with Licensed Vocational Nurse (LVN) 5 in Resident 194's room, Resident 194 was in the bed and watching television. Resident 194 has not had an indwelling catheter since 2023. LVN 5 stated, Resident 194 had it last year, but he pulled it out abruptly. LVN 5 stated, Resident 194 urinated without any difficulty after pulling it out. LVN 5 stated, Resident 194 refused an indwelling catheter insertion and the primary physician discontinue it. During a concurrent interview and record review on 7/11/2024, at 11:21 a.m. with the Interim Minimum Data Set Coordinator (IMDSC), Resident 194's MDS, dated [DATE] was reviewed. The MDS Section H (Bladder and Bowel) section indicated, Resident 194 had an indwelling catheter. The IMDSC stated, it was incorrectly coded because Resident 194 did not have an indwelling catheter when the assessment was done. The IMDSC stated, she confirmed there was no indwelling catheter after reviewing Resident 194's medical record. The IMDSC stated, incorrect coding (recording of Resident's assessment) could negatively affect the resident's plan of care. b. During a review of Resident 180's admission record, the admission record indicated Resident 180 was initially admitted to the facility on [DATE] and last readmission was on 5/23/2024 with diagnoses including schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), peripheral vascular disease (the reduced circulation of blood to a body part, other than the brain or heart, due to a narrowed or blocked blood vessel), venous insufficiency (a condition in which the veins have problems sending blood from the legs back to the heart), and protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function). During a review of Resident 180's H&P, dated 7/11/2024, the H&P indicated, Resident 180 did not have the capacity to understand and make decisions. During a review of Resident 180's MDS dated [DATE], the MDS indicated Resident 180 required dependent assistance from two or more staff for toileting hygiene, putting on/taking off footwear, maximal assistance from one staff for oral hygiene, shower/bathe self, upper body dressing, lower body dressing, personal hygiene, and supervision or touching assistance from one staff for eating, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, toilet transfer, tub/shower transfer. The MDS Section M (Skin Conditions) section indicated, Resident 180 had a stage 2 pressure ulcer/injury (partial thickness loss of tissue presenting as a shallow open ulcer with a red or pink wound bed, without slough [yellowish white material in the wound bed). During a review of Resident 180's Change in Condition Evaluation (COC), dated on 6/16/2024, the COC indicated, there was a stage 2 pressure injury on the left buttock without drainage. During a review of Resident 180's Progress Note (PN) by the wound specialist (physician), dated 6/19/2024, the PN indicated, that Resident 180's pressure injury on the left buttock had resolved from self-inflicted scratch. Not a pressure wound. During an interview on 7/10/2024, at 10:26 a.m., with Treatment Nurse (TN) 1, TN 1 stated, the licensed nurse who assessed the resident identified a pressure injury initially on 6/16/2024. TN 1 stated, this was reclassified as self-inflict skin ulcer by wound specialist on 6/19/2024. TN 1 stated, it was important to identify type of wound correctly, because the treatment would be determined by type of wound. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/11/2024, at 10:47 a.m., with the IMDSC, the IMDSC stated, the COC was done on 6/16/2024 as a pressure injury, and it was reclassified as self-inflict skin ulcer by the wound specialist on 6/19/2024. The IMDSC stated, the MDS was done on 6/20/2024 and it should have reflected s self-inflict skin ulcer instead of a pressure injury on MDS section M. The IMDS stated, it was coded incorrectly, and it could affect resident's treatment incorrectly. During an interview on 7/12/2024, at 9:10 a.m., with the Director of Nursing (DON), the DON stated, all assessment in the MDS should be coded correctly because this would affect resident's overall care and treatment negatively. During a review of facility's policy and procedure (P&P) titled, Resident Assessment, revised 1/2024, the P&P indicated, Policy Interpretation and Implementation . 6. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments . 11. All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. 12. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews. During a review of facility's P&P titled, Job Description: MDS Coordinator, dated 7/2020, the P&P indicated, Essential Duties . Administer patient assessments, oversee the assessment process, setting the assessment schedules and assuring that assessments are done in an accurate and timely manner. Coordinates the care plan as according to regulatory requirements . Review the resident's chart for specific treatments, medication orders, diets, etc., as necessary . Ensure that your nurses' notes reflect that the care plan is being followed when administering nursing care or treatment. Review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs . Assist the Resident Assessment/Care Plan Coordinator in planning, scheduling, and revising the MDS, including the implementation of RAPs and Triggers.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to ensure four of six sampled residents (Resident 165,125,101, and 62) care and services was provided to maintain good grooming and personal hygiene by: 1.Failing to provide fingernail care for Residents 165,125, and 101 who were unable to carry out activities of daily living to maintain good grooming. 2.Failing to provide oral hygiene (cleaning the mouth and tongue) for Resident 62, who needed total physical assistance with oral hygiene. This deficient practice had the potential for negative impact on Resident 165's,125's and 101's quality of life and self-esteem, and placed Resident 65 at risk for diseases of the mouth, and gums. Findings: a. During an observation on 7/8/2024 at 10:57 a.m., in Resident 165's room, Resident 165 was observed lying in bed. Resident 165's fingernails were long, and untrimmed and had a black substance underneath. During a review of Resident 165's Admission Record, the Admission Record indicated Resident 165 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, the ability to carry out the simples tasks), dementia (impaired ability to remember, think, or make decisions with doing everyday activities), hypertension (high blood pressure), and dysphagia (difficulty swallowing). During a review of Resident 165's Minimum Data Set ([MDS] a comprehensive standardized assessment and care-screening tool), dated 4/2/2024, the MDS indicated Resident 165's cognition was impaired. The MDS indicated Resident 165 had impairments (the state of function being weakened or damaged) on both sides of his upper extremities (upper part of the body that includes the shoulder, elbow, wrist, and hand). The MDS indicated Resident 165 was totally dependent (relying on someone else for care) from staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene. During a review of Resident 165's History and Physical (H&P), dated 3/29/2024, the H&P indicated Resident 165 did not have the capacity to make decisions. During a concurrent observation and interview on 7/8/2024 at 11:05 a.m., in Resident 165's room with Licensed Vocational Nurse (LVN4), LVN 4 confirmed Resident 165's fingernails were long and had a black substance underneath them. LVN 4 stated that would indicate that no one was cleaning or trimming his fingernails. LVN 4 stated Certified Nursing Assistant (CNAs) were responsible for keeping residents' fingernails clean, especially for the residents that were dependent on the facility staff for personal hygiene. LVN 4 stated dirty fingernails placed Resident 165 at risk for infections because any germs or bacteria that were underneath his fingernails could enter his bloodstream, and the nails should be trimmed to prevent skin cuts, and injuries. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a concurrent observation and interview on 7/8/2024 at 11:12 a.m., in Resident 125's room with Resident 125. Resident 125 lying in bed watching television. Resident 125's fingernails were long and dirty with a black substance under all ten fingernails. Resident 125 stated he doesn't remember the last time his fingernails were cleaned or cut. Resident 125 stated he would like to have his fingernails cleaned and cut by staff. During a review of Resident 125's Admission Record, the Admission Record indicated Resident 125 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease ([COPD] a group of diseases that cause airflow blockage and breathing-related problems), hypertension, dysphagia, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly),dementia (impaired ability to remember, think, or make decisions with doing everyday activities), and muscle weakness (lack of muscle strength). During a review of Resident 125's MDS, dated [DATE], the MDS indicated Resident 125 was totally dependent from staff for dressing, toileting hygiene, and require maximum assistance (helper does more than half the effort) for oral hygiene, and personal hygiene. During a review of Resident 125's H&P, dated 8/30/2023, the H&P indicated Resident 125 was alert and oriented to person, place, and time. Resident 125 did not have the capacity to make medical decisions. During a concurrent observation and interview on 7/9/2024 at 12:03 p.m., in Resident 125's room with CNA2. CNA 2 stated CNAs are responsible for cleaning and trimming residents' fingernails. CNA 2 acknowledge that Resident 125's fingernails were long and unclean. CNA 2 stated Resident 125 refuses to have his fingernails cleaned and trimmed. CNA2 stated she doesn't know why Resident 125 refuses care. CNA 2 stated residents' fingernails should be cleaned daily and trimmed as needed. CNA 2 stated it was important for Resident 125's fingernails to be clean and trim to prevent infection, cuts, and injuries. c. During an observation on 7/9/2024 at 8:24 a.m., in Resident 101's room, Resident 101 was observed with untrimmed long fingernails with a black substance underneath. During a review of Resident 101's Admission Record, the Admission Record indicated Resident 101 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, hypertension, dementia, and dysphagia. During a review of Resident 101's MDS, dated [DATE], the MDS indicated Resident 101 required maximum assistance from staff for Activities of Daily Living (ADLs). During a review of Resident 101's H&P, dated 8/9/2023, the H&P indicated Resident 101 can make needs known but cannot make decisions. During an interview on 7/9/2024 at 12:47 p.m., with LVN 3. LVN 3 stated long and dirty fingernails are a safety risk and puts resident at risk for infections. LVN 3 stated Resident 101 can scratch himself or the staff, and long fingernails can grow bacteria, fungus (living thing produce organisms), and infection. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 87)was positioned properly by a nursing staff during resident care by failing to identify and recognize a bedside drawer located next to the resident's bed as a potential hazard to resident's safety during care which led to resident hitting the nightstand during repositioning. This failure placed Resident 87 at risk for fall and serious injury. Findings: During a review of Resident 87's Admission Record, the Admission Record indicated the resident was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses that included unspecified sequalae (consequences) of cerebral infarction (a stroke with full recovery or minor lingering deficits with minimal impact on daily life after a stroke), vascular dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by impaired blood flow to brain), lack of coordination and cognitive communication deficit (person has trouble participating in conversations, has difficulty understanding what is said and unable to respond or has trouble speaking clearly). During a review of Resident 87's History and Physical (H&P) dated 3/14/2024, the H&P indicated the resident had no capacity to make decisions. During a review of Resident 87's Minimum Data Set [MDS] standardized screening tool) dated 5/17/2024, the MDS indicated the resident had severely impaired cognitive skills (problems with person's ability to think, learn, remember, use judgement, and make decisions) for decision making. The MDS indicated the resident had impairment on both upper and lower extremities (arms and legs) and required substantial or maximal assistance (helper does more than half the effort) with bed mobility. The MDS indicated the resident was dependent on the staff with toileting hygiene and bathing. During a review of Resident 87's Change of Condition([COC] a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional condition) dated 6/23/2024, at 9:33 p.m., the COC indicated the resident hit the right side of his forehead on a bedside drawer, sustaining a cut measuring 2 centimeter ([cm] unit of measurement of length) by 0.5 cm in size while being turned to the right side of the bed. During a review of Resident 87's Nursing- Comprehensive Skin Evaluation assessment dated [DATE] at 8:18 a.m., the Comprehensive Skin Evaluation/ Assessment indicated the resident had 2 cm. by .5 cm laceration(cut) on the right forehead and steri strips (strips of tape put across an incision or cut and keep edges of the wound together)were applied. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 87's Care Plan regarding Resident 87's high risk for falls and injuries initiated on 8/25/2021 due to muscle weakness, stroke, vascular dementia, and cognitive communication deficit, the Care Plan's goal indicated the resident would have no injuries related to falls. The Care Plan's interventions included to keep the environment free from obstruction and evaluate possible medical, physical, cognitive, and psychiatric conditions. During a concurrent observation and interview at Resident 87's room with Certified Nursing Assistant (CNA 5) on 7/10/2024, at 2:10 p.m., a bedside drawer was in close proximity to Resident 87's bed. CNA 5 stated Resident 87 was confused, required a one person assist during positioning in bed and needed clear, repeated instructions to obtain cooperation from the resident. CNA 5 stated and demonstrated how to turn Resident 87 to the right side of the bed. CNA 5 positioned himself on the left side of the resident, raised the bed to his waist level, then pulled the drawsheet closer to his body and pretended to turn a resident to his right side. CNA 5 stated Resident 87 should not be close to the bedside drawer when being turned or too close to the right side of the bed because the resident could roll over from the bed or hit the bedside drawer. During an interview on 7/10/2024, at 2:16 p.m., with CNA 6, CNA 6 stated Resident 87 could not carry a conversation and had not heard him talk. CNA 6 stated if she would reposition Resident 87 or other residents, she would raise the bed to her hip level to prevent her from getting injured, pull the resident towards her to prevent him from falling or getting too close to the bedside drawer . CNA 6 stated the resident could hit the bedside drawer or fall that could lead to brain injury, bruising (part of the body is injured, blood from damaged small blood vessel leak out and gets trapped under the skin forming a red or purplish mark) or a fracture (broken bone) if resident was turned too close to the edge of the bed. During an interview on 7/10/2024, at 3:27 p.m. with CNA 7, CNA 7 stated he was cleaning Resident 87 because the resident had a bowel movement (movement of feces through the bowel and out the anus). CNA 7 stated Resident 87 was not pulled closer to him before he was turned to his right side. CNA7 stated Resident 87 had a cut in the right side of the forehead after the turn and he notified his charge nurse and RN Supervisor right away. CNA 7 stated he should have pulled Resident 87 closer to him before turning him to the right side to avoid getting hit by the furniture close to the bed. During a phone interview on 7/11/2024, at 12:24 p.m. with Director of Staff Development (DSD), the DSD stated when repositioning a resident proper body mechanics (proper body positioning during movement) are used by staff and the staff should ensure resident's body is in good alignment. DSD stated staff should ensure the bed was at the waistline , brakes of bed are locked, and surrounding areas of the resident is safe by removing or avoiding anything that gets in the way of the resident before repositioning or turning for safety and avoidance of injury. During an interview on 7/11/2024, at 1:55 p.m. with Licensed Vocational Nurse (LVN 6), LVN 6 stated he was called by CNA 7 to check Resident 87 when the incident happened. LVN 6 stated Resident 87 had slight swelling and laceration on his right forehead. LVN 6 stated CNA7 was turning the resident and the resident accidentally hit his head on the bedside drawer. LVN 6 stated residents could fall off the bed or hit the furniture and the staff could hurt themselves by overextending their body if the residents are repositioned or turned too close to the side of the bed and away from the staff. LVN 6 stated residents should be close to staff's body and not too close to the other side of the bed before turning or repositioning them to avoid injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/12/2024, 1:10 p.m. with Interim Director of Nursing (IDON), the IDON stated when repositioning or turning a resident the staff should pull the residents close to them by pulling the sheets so there is enough space for turning. The IDON stated if there was not enough space for resident during repositioning, there is a potential for injury because rails and bedside drawer can cause injury to the resident. During a review of facility's policy and procedure(P/P) titled Safety and Supervision of Residents dated 2001, the P/P indicated resident safety and supervision and assistance to prevent accidents are facility wide priorities. The P/P indicated employees are trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on observation, interview and record review, the facility failed to ensure a resident was provided a therapeutic diet (a prescribed meal plan that controls certain aspects of nutrients and/or foods as part of a treatment plan) as ordered by the physician for one of three sampled residents (Resident 194). This failure had the potential for Resident 194 to choke (occurs when a foreign object lodges in the throat, blocking the flow of air) and aspiration (inhaling small particles of food or drops of liquid into the lungs.) Findings: During a review of Resident 194's admission record, the admission record indicated Resident 194 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest),and lack of coordination (a lack of muscle coordination and control). During a review of Resident 194's History and Physical (H&P), dated 4/25/2024, the H&P indicated, Resident 194 did not have the capacity to understand and make decisions. During a review of Resident 194's Minimum Data Set ([MDS]-a standardized assessment and care screening tool), dated 6/10/2024, the MDS indicated Resident 194 required dependent assistance (Helper does all of the effort) from two or more staff for oral hygiene, toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, personal hygiene, sit to stand, chair/bed to chair transfer, toilet transfer, tub/shower transfer, maximal assistance (Helper does more than half the effort) from one staff for upper body dressing, roll left and right, sit to lying, lying to sitting on side of bed, and supervision or touching assistance (Helper provides verbal cues and /or touching/steadying and /or contact guard assistances as resident completes activity) from one staff for eating. The MDS Section K (Swallowing/Nutritional Status) indicated, Resident 194 was on a mechanically altered diet (A diet specifically prepared to alter the texture or consistency of food that is easy to swallow because they are blended, chopped, grinded, or mashed so that they are easy to chew and swallow) that required change in texture of food or liquid. During a review of Resident 194's Order Summary Report (OSR), dated 6/10/2024, the OSR indicated, dysphagia (difficult swallowing) mechanical soft texture with thin liquid consistency diet including additional two servings of vegetables and fruit for dessert was ordered on 1/29/2024. During a review of Resident 194's Care Plan (CP), dated 3/13/2023, the CP focus indicated, Resident 194 was at nutrition risk. The CP interventions indicated, assist with meals as needed and provide diet as ordered. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Weekly Menu (WM), dated from 7/8/2024 to 7/14/2024, the WM indicated, old fashioned meatloaf with gravy, herb mashed potatoes, seasoned fresh vegetables, pan biscuit, and Ice cream was served for lunch on 7/8/2024. During a review of facility's Cook's Spreadsheet (CS), undated, the CS indicated, old fashioned meatloaf for dysphagia mechanical should be mashable and moist with gravy. The CS indicated, seasoned fresh vegetables should be mashable. During a concurrent observation and interview on 7/8/2024, at 1:32 p.m., with Certified Nurse Assistant (CNA)1, in Resident 194's room, Resident 194 was eating lunch and there was small piece of meat left on the plate. CNA 1 brought the lunch tray for Resident 194. CNA 1 stated, another CNA served the wrong lunch tray to Resident 194. The lunch tray that Resident 194 ate belonged to his roommate who was on a regular fortified diet (A food that has extra nutrients added to it or has nutrients added that are not normally there). CNA 1 stated, Resident 194 was on a mechanical soft diet with pureed vegetablse and fruits. CNA 1 stated, the other CNA should have checked Resident 194's name before serving the tray. CNA 1 stated, Resident 194 could choke on the consistency of a regular diet. During an interview on 7/8/2024, at 1:34 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, she just got informed from CNA 1 that Resident 194 was served with the wrong tray. LVN 2 stated, Resident 1 ate his roommate's tray which was regular diet with regular texture. LVN 2 stated, vegetables and fruits should be pureed per speech therapist (A specialist who evaluates and treats people with communication and swallowing problems). LVN 2 stated, Resident 194 was a high risk for chocking and aspiration. During an interview on 7/10/2024, 9:55 a.m., with the Registered Dietitian (RD), the RD stated, Resident 194 was on a mechanical soft diet with mashable vegetable and pureed fruits. RD stated, meat should be mashable and moist with gravy. RD stated, Resident 194 should be served with diet as ordered by physician for safety because of possible chocking and aspiration. During an interview on 7/11/2024, at 2:22 p.m., with Speech Therapist (ST) 1, ST 1 stated, Resident194 was on therapeutic diet due to muscle weakness. ST 1 stated, serving wrong tray could have ended up in the resident chocking, getting aspiration pneumonia (infection of the lungs or large airways. Aspiration pneumonia occurs when food or liquid is breathed into the airways or lungs, instead of being swallowed) and death. ST 1 stated that all staff should follow and serve the diet as ordered by physician for safety. During an interview on 7/12/2024, at 9:10 a.m., with Interim Director of Nursing (IDON), IDON stated, staff should have checked the resident's name before serving the tray because the resident could have choked or aspirated. IDON stated, residents' safety was the number one priority for the facility. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P) titled, Therapeutic Diets, revised 5/2024, the P&P indicated, Policy Statement: Therapeutic diets are prescribed by the Attending Physician to support the resident's treatment and plan of care in accordance with his or her goals and preferences. Policy Interpretation and Implementation . 4.'therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example . d. Altered consistency diet. 5. If a mechanically altered diet is ordered, the provider will specify the texture modification. During a review of facility's P&) titled, NUTRITION MANAGEMENT OF DYSPHAGIA, dated 2023, the P&P indicated, Description: Dysphagia is characterized by coughing or choking after swallowing, pocketing of food in the cheek, excessive drooling, runny nose, or eyes, gargled voice after eating, or poor tongue control . Dysphagia Mechanical Diet: This diet consists of foods that are moist, mechanically altered, easily mashed, or pureed. This is necessary to form a cohesive bolus requiring little chewing. Foods must not be sticky or bulky increasing the risk of airway obstruction . General Principles: Foods served should form a cohesive bolus and not fall apart when swallowed . Foods that are sticky or bulky should be avoided as they can cause obstruction of the airway. During a review of facility's P&P titled, REGULAR MECHANICAL SOFT DIET, dated 2023, the P&P indicated, DESCRIPTION: The mechanical soft diet is designed for residents who experience chewing or swallowing limitations. The regular diet is modified by mechanically altering, by chopping or grinding, allowable food items and/or cooking raw items to a soft texture. Food items that may need to be modified include proteins, raw vegetables, raw fruit, and all other fibrous foods. Meats, Poultry and Fish-ground wit meat juices, gravy or sauce is allowed. Whole or chopped, dry meat needed to avoid .Cooked Vegetables-mashed or soft (be able to mash with fork) whole vegetables is allowed. During a review of facility's policy and procedure P&P titled, Job Description: Certified Nursing Assistant, dated 2/2019, the P&P indicated, Essential Duties . Assist residents with identifying food arrangements . Perform after meal care.

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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	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** 36943 Based on observation, interview, and record review, the facility did not provide accurate documentation for two of nine sampled residents (Resident 73 and 64) with limited range of motion [ROM, full movement potential of a joint (where two bones meet)] and mobility (ability to move). a. Resident 73's clinical record for Restorative Nursing Aide (RNA, certified nursing aide program that helps residents to maintain their function and joint mobility) tasks did not include passive range of motion (PROM, movement of joint through the ROM with no effort from the person) exercises to both legs and application of an abductor pillow (cushion used to separate a person's legs) to both legs were performed from 3/11/2024 to 5/2/2024. b. Resident 64's clinical record for RNA tasks did not indicate PROM exercises to both legs were performed from 2/19/2024 to 4/19/2024. These failures provided inaccurate records of the RNA services provided to Resident 73 and 64. Findings: During a review of Resident 73's Admission Record, the Admission Record indicated the facility admitted Resident 73 on 10/26/2022 and readmitted on [DATE] with diagnoses including dementia (decline in mental ability severe enough to interfere with daily life), major depressive disorder (depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily functioning), muscle weakness, and a left displaced (bone moved out of its original position) femoral neck (narrow portion of the hip bone) fracture (break in the bone). During a review of Resident 73's Minimum Data Set ([MDS] a comprehensive assessment and care planning tool), dated 1/30/2024, the MDS indicated Resident 73 had clear speech, expressed ideas and wants, clearly understood verbal content, and had severely impaired cognition. The MDS indicated Resident 73 was dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for eating, oral hygiene (ability to use suitable items to clean teeth), toileting, showering/bathing, lower body dressing, and chair/bed-to-chair transfers. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 73's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment, dated 2/2/2024, the PT Evaluation indicated Resident 73 was referred to PT due to a decline in functional mobility and refusals with the RNA program. The PT Evaluation indicated Resident 73's ROM in both hips and both knees were impaired, including left hip flexion (bending the leg at the hip joint toward the body) 0 to 30 degrees (0-30 degrees, normal 0-120 degrees), right hip flexion 0-60 degrees, left knee flexion (bending the knee) 0-30 degrees (normal 0-135 degrees), and right knee flexion 0-60 degrees. The PT Evaluation indicated Resident 73 laid supine (back on bed) with the right leg positioned on top of the left leg with noted stiffness to both legs. The PT Plan of Treatment included therapeutic exercises (movement prescribed to correct impairments and restore muscle function), neuromuscular reeducation (technique used to restore movement patterns through repetitive motion to retrain the brain), and therapeutic activities (tasks that improve the ability to perform activities of daily living {[ADLs] tasks related to personal care including bathing, dressing, hygiene, eating, and mobility}), four times per week for four weeks. During a review of Resident 73's PT Discharge Summary, dated 3/8/2024, the PT Discharge Summary indicated Resident 73's ROM in both legs improved, including 0-45 degrees left hip flexion, 0-90 degrees right hip flexion, 0-45 degrees left knee flexion, and 0-90 degrees right knee flexion. Resident 73's PT Discharge Summary recommendations included RNA to perform PROM to both legs. During a review of Resident 73's Order Listing Report (report of physician orders) included physician orders, dated 3/11/2024, the Order Listing Report indicatedvfor RNA to perform PROM to both legs as tolerated, five times per week, and application of an abductor pillow when supine in bed, five days per week. During a review of Resident 73's Documentation Survey Report (record of nursing assistant tasks) for RNA, dated 3/2024, 4/2024, and 5/2024,the Documentation Survey Report did not include RNA to perform PROM to both legs and to apply an abductor pillow. During a review of Resident 73's RNA Weekly Summary, dated 3/12/2024, 3/19/2024, 3/26/2024, 4/2/2024, 4/9/2024, 4/16/2024, and 4/23/2024,the RNA Weekly Summary indicated the RNA performed PROM to both legs, five times per week. Resident 73's RNA Weekly Summaries also indicated the RNA placed a cushion between Resident 73's legs to keep them separated and to prevent them from crossing. During an observation and interview on 7/10/2024 at 11:40 a.m. in Resident 73's bedroom, Resident 73 was awake, alert, and sitting up in a gerichair (reclining chair that allows someone to get out of bed and sit comfortably in different positions while fully supported). Resident 73's right leg was crossed over the left leg. Resident 73 spoke words without logical conversation. During a concurrent interview and record review on 7/10/2024 at 2:40 p.m. with Physical Therapist 1 (PT 1), Resident 73's PT Evaluation, dated 2/2/2024, and PT Discharge Summary, dated 3/8/2024, were reviewed. PT 1 stated Resident 73's ROM during the PT Evaluation was limited in both legs, including the left hip 0-30 degrees, right hip 0-60 degrees, left knee 0-20 degrees, and right knee 0-60 degrees. PT 1 stated Resident 73 was discharged on [DATE] with improved ROM to left hip 0-45 degrees, right hip 0-90 degrees, left knee 0-45 degrees, and right knee 0-90 degrees. PT 1 recommended RNA to provide PROM on both legs and to apply an abductor pillow because Resident 73 had a habit of crossing the right leg over the left leg. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/11/2024 at 3:30 p.m. with the Regional Quality Assurance Nurse (Regional QA), Resident 73's Documentation Survey Reports from 3/2024 to 5/2024 and RNA Weekly Summaries from 3/12/2024 to 4/23/2024 were reviewed. The Regional QA stated Resident 73's task for RNA to perform PROM to both legs and apply the abductor pillow was entered in the facility's electronic documentation system but the staff member (unknown) who entered the task did not click a check mark, which sends the task to the RNA documentation. The Regional QA stated Resident 73's RNA Weekly Summaries indicated the RNAs were providing Resident 73 PROM to both legs and applying the abduction pillow, five times per week. During an interview on 7/11/2024 at 4:05 p.m., the Regional QA stated Resident 73's Documentation Survey Report for RNA from 3/2024 to 5/2024 was incomplete since they did not include the RNA task for PROM to both legs and application of the abduction pillow. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised 5/2024, the P&P indicated all services provided to the resident shall be document in the resident's medical record. The P&P also indicated documentation in the medical record will be objective, complete, and accurate. b. During a review of Resident 64's Admission Record, the Admission Record indicated the facility admitted Resident 64 on 3/31/2010 and readmitted on [DATE] with diagnoses including Type 2 diabetes (high blood sugar), epilepsy (abnormal electrical activity in the brain marked by sudden, recurrent episodes of loss of consciousness or uncontrolled body shaking), cerebral infarction (brain damage due to a loss of oxygen to the area), muscle weakness, right knee contracture (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness), acquired absence of the left leg below knee, and dysphagia (difficulty swallowing). During a review of Resident 6 MDS, dated [DATE],the MDS indicated Resident 64 did not have any speech, rarely expressed ideas and wants, rarely understood verbal content, and was severely impaired for daily decision making. The MDS indicated Resident 64 had ROM impairments in both arms and legs and dependent (helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity) for oral hygiene, toileting, showering/bathing, dressing, rolling to either side in bed, and chair/bed-to-chair transfers. During a review of Resident 64's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Discharge Summary, dated 2/16/2024, the PT Discharge Summary indicated the RNA program was developed for PROM to both legs. The PT Discharge Summary recommendations indicated for the RNA to provide Resident 64 with PROM. During a review of Resident 64's Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Discharge Summary, dated 2/17/2024, the OT Discharge Summary indicated Resident 64 tolerated wearing a resting hand splint (material secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist and prevent contractures) on the left hand for three hours. The OT Discharge Summary recommendations indicated for the RNA to provide Resident 64 with PROM to both arms and to apply the left-hand splint for three hours, five times per week as tolerated. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 64's physician orders, dated 2/17/2024,the physician's order included a RNA program for PROM exercises to both arms and application of the left resting hand splint for three hours or as tolerated. Another physician order, dated 2/19/2024, indicated RNA for PROM exercises to both legs, five times per week as tolerated. During a review of Resident 64's Documentation Survey Report (record of nursing assistant tasks) for RNA for the months of 2/2024, 3/2024, and 4/2024,the Documentation Survey Report indicated Resident 64 received RNA for PROM exercises to both arms and application of the left resting hand splint. During a review of Resident 63's Documentation Survey Report for RNA for 2/2024 the Documentation Survey Report indicated NA (not applicable) or N (no) for PROM exercises to both legs, five times per week, on 2/18/2024 to 2/24/2024 and 2/26/2024 to 2/29/2024. During a review of Resident 63's Documentation Survey Report for RNA for 3/2024 the Documentation Survey Report indicated NA or N for PROM exercises to both legs, five times per week on 3/1/2024, 3/4/2024 to 3/8/2024, 3/11/2024 to 3/15/2024, 3/18/2024 to 3/22/2024, and 3/25/2024 to 3/29/2024. During a review of Resident 63's Documentation Survey Report for RN for 4/2024, the Documentation Survey Report indicated NA or N for PROM exercises to both legs, five times per week on 4/1/2024 to 4/5/2024, 4/8/2024 to 4/12/2024, and 4/15/2024 to 4/19/2024. During review of Resident 63's RNA Weekly Summary, dated 2/28/2024, 3/6/2024, 3/13/2024, 3/20/2024, 3/28/2024, 4/4/2024, 4/10/2024, 4/17/2024, and 4/24/2024, the Weekly Summary indicated Resident 63 received RNA for PROM to both arms and both legs and applied the left resting hand splint. During a review of Resident 63's physician orders, dated 4/19/2024,the physician orders indicated to discontinue RNA for PROM to both arms and legs and application of the left resting hand splint. During a concurrent interview and record review on 7/11/2024 at 12:24 p.m. with the Director of Rehabilitation (DOR), Resident 64's OT Discharge Summary, dated 2/17/2024, and PT Discharge Summary, dated 2/16/2024. The DOR stated Resident 64's OT Discharge recommendations indicated for RNA to perform PROM to both arms and apply the left resting hand splint. The DOR stated Resident 63's PT Discharge recommendations indicated for RNA to perform PROM to both legs. During a concurrent interview and record review on 7/1/2024 at 4:08 p.m. with the Regional Quality Assurance Nurse (Regional QA), Resident 64's physician orders for RNA, dated 2/17/2024 and 2/19/2024, and Documentation Survey Report for RNA from 2/2024 to 4/2024 were reviewed. The Regional QA stated the physician orders, dated 2/17/2024, indicated for RNA to provide PROM to both arms and apply the left-hand splint. The Regional QA stated the physician orders, dated 2/19/2024, indicated for the RNA to provide PROM to both legs. The Regional QA stated Resident 64's task for the RNA to perform PROM exercises to both legs was entered in the facility's electronic documentation system in a manner that provided limited choices for the RNA to document the session, including N for no, NA for not applicable, or RR for resident refused. The Regional QA stated Resident 64's RNA Weekly Summaries indicated the RNAs were provided Resident 64 PROM to both arms and legs and applying the left resting hand splint. The Regional QA stated Resident 64's Documentation Survey Report for RNA from 2/19/2024 to 4/19/2024 was inaccurate for PROM to both legs since it did not reflect the treatment provided to Resident 64. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/12/2024 at 9:05 a.m. with Restorative Nursing Aide 4 (RNA 4), Resident 64's Documentation Survey Report for RNA from 2/2024 to 4/2024 were reviewed. RNA 4 stated Resident 64's RNA program included PROM exercises to both arms and legs and application of the left-hand splint. RNA 4 stated the Documentation Survey Reports indicated N or NA responses because the electronic documentation system to record Resident 64's RNA sessions had limited selections that did not reflect the PROM exercises provided to Resident 64's legs. RNA 4 stated she should have notified medical records to fix the RNA task for Resident 64 because the Documentation Survey Report indicated as if RNA 4 did not provide PROM exercises to Resident 64's legs. During a review of the facility's P&P titled, Charting and Documentation, revised 5/2024, the P&P indicated all services provided to the resident shall be document in the resident's medical record. The P&P also indicated documentation in the medical record will be objective, complete, and accurate.

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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. 49145 Based on observation, interview, and record review, the facility failed to: a)Ensure one of four washing machines were working properly. b)Ensure washing machine and dryer temperatures were being monitored daily. These failures had the potential to result in the spread of infection throughout the facility. Findings: During a concurrent observation and interview on 7/9/2024 at 7:30 a.m., in the laundry room, one of the washing machines (washing machine #4) while running, was leaking water from the left side and from the door of the washing machine. Washing machine #4 leaking, was verbally confirmed by the Assistant Administrator (AADMIN) and the Maintenance Supervisor (MS). The MS stated he was unaware the washing machine was leaking water. During an interview on 7/9/2024 at 7:30 a.m., with the MS, the MS stated they do not have temperature monitoring logs for the washing machines or dryers. The MS stated the laundry supervisor and himself are responsible for checking the temperatures of the washing machines and dryers daily, but they do not log it anywhere. During an interview on 7/11/2024 at 7:30 a.m., with the MS, the MS stated his staff know to check the washing machine and dryer temperatures daily, but he has no proof that it is being done. During an interview on 7/11/2024 at 3:08 p.m., with the Infection Prevention Nurse (IPN), the IPN stated there should be monitoring logs for the washing machines and dryers because it is crucial in the prevention of the spread of infections. The IPN stated if the washing machine and dryer temperatures are not being monitored, this could potentially lead to an outbreak in the facility. During an interview on 7/12/2024 at 9:09 a.m., with the Interim Director of Nursing (IDON), the IDON stated it was important to have temperature monitoring logs for the washing machines and dryers to ensure they are at the proper heat to kill bacteria and prevent the spread of infection. During a review of the facility's Laundry Aide Job Description, dated 2017, the Laundry Aide Job Description indicated their duties are to use all laundry equipment and supplies in a safe manner. During a review of the facility's Laundry Supervisor Job Description, undated, the Laundry Supervisor Job Description indicated their duties are to report laundry equipment issues to supervisor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Maintenance Director Job Description, dated 9/2018, the Maintenance Director Job Description indicated their duties are to Ensure that supplies, equipment, etc., are maintained to provide a safe and comfortable environment. Make periodic rounds to check equipment and to assure that necessary equipment is available and working properly. Assist the Infection Control Coordinator in identifying, evaluating, and classifying routine and job-related maintenance functions to ensure that involving the potential exposure to blood/body fluids are properly identified and recorded.

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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** 45269 Based on observation, 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 7/8/2024, the facility had 43 rooms that measured less than 80 sq. ft. per resident in multi-bedrooms and two rooms that measured less than 100 sq. ft for a single bedroom. The resident rooms were as follow: Palm 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. 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. During observations, from 7/8/2024 through 7/10/2024, 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 an 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. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	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.