STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555565	A. Building B. Wing	01/10/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on observation, interview and record review, the facility failed to ensure residents were protected from abuse in the smoking patio area when Resident 54 hit Resident 11 on the nose. As a result of this failure, Resident 11 sustained a nosebleed and had to be sent out to the hospital for further evaluation and treatment. Findings: During a review of Resident 11's Admission Record, the Admission Record indicated Resident 11 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), and insomnia (trouble falling asleep or staying asleep). During a review of Resident 11's Minimum Data Set ([MDS], a resident assessment tool), dated 10/16/2024, the MDS indicated Resident 11 had severe cognitive (thinking process) impairment. The MDS also indicated Resident 11 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity) for self-care abilities such as eating and needed moderate assistance (helper does less than half the effort. helper lifts, hold or supports trunk or limbs but provides less than half the effort) for self-care abilities such as oral hygiene, toileting hygiene, upper and lower body dressing, putting on and taking off footwear and personal hygiene and mobility such as rolling left and right, sit to lying position, lying to sitting position, sit to stand position, and transfers. During a review of Resident 11's history and physical (H&P) dated 10/7/2024, the H&P indicated Resident 11 did not have the capacity to understand and make decisions. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 11's Interdisciplinary Team (IDT, team members from different departments working together, to set goals, make decisions that ensure residents receive the best care) Nurse's Note dated 1/7/2025, the IDT Nurse's Note indicated on 1/6/2025 nursing staff was in the Court Station patio to supervise residents during their smoke break, when they heard screaming. The IDT Nurse's Note indicated staff assessed immediately and noted Resident 11 in wheelchair with blood coming from his nose. The IDT Nurse's Note indicated Resident 11 reported that he had an altercation with Resident 54. The IDT Nurse's Note indicated Residents 11 and 54 were kept separated and assessed for injuries. Resident 11 was noted with a hematoma (a dark area on the skin due to broken blood vessels pooling under the skin) on the bridge of Resident 11's nose upon skin assessment and an abrasion (wound) on the 3rd metacarpal (bones of the hand). Xray (diagnostic imaging test) completed revealing normal facial series. If clinical concern or symptoms continue to exist, further work up should be considered. Order given to transfer to hospital for further evaluation and treatment secondary to x-ray results. During a review of Resident 11's Order Summary Report, the Order Summary Report indicated may transfer to hospital for further evaluation and treatment related to x-ray results ordered on 1/7/2025. During a review of Resident 11's GACH (general acute care hospital) records dated 1/7/2025, the GACH records indicated chief complaint was nasal injury and that patient got in an altercation with another resident with subsequent nose injury and bleeding. The GACH records indicated the facility sent patient for further tests to rule out intracranial (within the brain) bleeding. During a review of Resident 54's Admission Record, the Admission Record indicated Resident 54 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder, schizophrenia, and anxiety disorder. During a review of Resident 54's MDS, dated [DATE], the MDS indicated Resident 54 had intact cognitive ability. The MDS also indicated Resident 54 required supervision for self-care abilities such as eating, and oral hygiene and needed moderate assistance for self-care abilities such as toileting, shower/bathe, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS also indicated Resident 54 required supervision for mobility such as rolling left and right, sit to lying position, lying to sitting on the side of bed, sit to stand position and transfers. During a review of Resident 54's H&P dated 2/12/2024, the H&P indicated Resident 54 was able to make decisions. During a review of Resident 54's Psychology (medical field specializing in treatment of mental illness) consult note dated 12/8/2024, the Psychology consult note indicated Resident 54 was referred to be seen by social services staff following verbal confrontations with staff involving money. The Psychology consult note indicated Resident 54 did not acknowledge or remember verbal disputes with staff members. The Psychology Consult Note indicated Resident 54 presented with agitation (restlessness, uneasiness) hyper-verbal speech (speaking quickly and frequently, sometimes to the point of interrupting others) and symptoms including paranoia (severe distrust of others not rooted in reality) and a response to auditory hallucinations (hearing things that do not exist in realty). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 54's IDT Nurse's Note dated 1/7/2025, the IDT Nurse's Notes indicated that the resident was involved in a physical altercation with Resident 11. The IDT Nurse's Notes indicated the residents were separated and assessed for injuries. The IDT Nurse's Note indicated Resident 54 stated he asked Resident 11 if he took his money and then struck Resident 11 on the nose with a closed hand. The IDT Nurse's Note indicated Nursing staff performed head to toe assessment with no injuries noted and Resident 54 was sent out to hospital for further evaluation and treatment as indicated for physical aggression. During a review of Resident 54's Order Summary Report, the Order Summary Report indicated resident may transfer to hospital for further evaluation related to aggression ordered on 1/6/2025. During a concurrent observation and interview on 1/8/2025 at 9:06 a.m., with Resident 11 in his room, Resident 11 was sitting in his wheelchair. Resident 11's nose appeared a little swollen at the bridge of his nose. Resident 11 stated on 1/7/2025 he was sent to the hospital for his nose because he could not breathe well from his nose. During an observation on 1/8/2025 at 8:58 a.m., in Resident 54's room, there was no one in the room. The bed was made, and room was clean. During an interview on 1/10/2025 at 5:19 p.m., with the Director of Nursing (DON), the DON stated the Assistant Director of Nursing (ADON) 1 was around the smoking patio area when the altercation happened in the smoking patio area. The DON stated that CNA 3 should have been in the smoking patio area as well but was tending to another resident in his room when Resident 54 told CNA 3 that Resident 11 took his money. The DON stated he got a call from CNA 3 that Resident 54 hit Resident 11 and he went to the smoking patio area to assess the residents. During a telephone interview on 1/13/2025 at 10:27a.m, with CNA 4, CNA 4 stated he was in the hallway of the unit charting by the smoking patio area when the incident happened. CNA 4 stated that CNA 3 went to him in the hallway and told him that Resident 54 hit Resident 11. CNA 4 stated he ran to the smoking patio area that was located outside and saw Resident 11's face full of blood. CNA 4 stated he took Resident 11 to his room to clean him up. During a telephone interview on 1/13/2025 at 10:39 a.m., with CNA 3, CNA 3 stated he was not in the smoking patio area outside when the incident happened between Resident 54 and Resident 11. CNA 3 stated he was inside tending to another resident in room [ROOM NUMBER] when Resident 54 came to tell him that Resident 11 took his money, and then Resident 54 walked out of the room assuming to the smoking patio area outside. CNA 3 stated when he finished helping the Resident (unidentified) in room [ROOM NUMBER] and wheeled him to the smoking patio area the incident between Resident 54 and Resident 11 had already happened and ADON 1 was already there. During a telephone interview on 1/13/2025 at 10:49 a.m., with ADON 1, ADON 1 stated he was in the smoking patio area walking, doing his rounds when the incident happened. ADON 1 stated he had his back turned to the residents during the altercation as he was tending to another resident in the smoking patio area. ADON 1 stated the incident happened so fast that he did not see Resident 54 hit Resident 11 but heard the incident happened behind him. ADON 1 stated Resident 54 rushed back inside the unit and staff came to render first aid to Resident 11. ADON 1 stated the DON and Administrator were notified and came to assess the situation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P/P) titled Abuse Neglect, Exploitation and Misappropriation Prevention Program dated May 2024, the P/P indicated residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms .protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to facility staff; other residents; any other individual .ensure adequate staffing and oversight/support to prevent burnout, stressful working situations and high turnover rates.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144 Based on observation, interview and record review, the facility failed to ensure care plan interventions for one of three sampled residents (Resident 110) were implemented. The facility failed to implement Resident 110's care plan intervention to wear a med alert bracelet that indicates to staff that Resident 110 is on anticoagulant therapy (also known as blood thinning therapy, is the use of medications to prevent or treat blood clots.) This deficient practice had the potential to result in delayed care and services and decline in Resident 110. Findings: During a review of Resident 110's Admission Record, the admission record indicated Resident 110 was originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including displaced spiral fracture of shaft of left femur (a type of a break of the thigh bone that is broken in a spiral pattern, resulting in misalignment and separation of the bone fragments), atherosclerotic disease of native coronary artery without angina pectoris (a heart disease with blood flow problems due to plaque buildup in arteries without symptom of chest pain), and heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 110's History and Physical (H&P), dated 8/1/2024, the H&P indicated Resident 110 had the capacity to understand and make decisions. During a concurrent observation and interview on 1/9/2025 at 1:18 p.m., with Resident 110, Resident 110 did have a bracelet indicating anticoagulant therapy. Resident 110 stated they have never had a bracelet for blood thinners. During a concurrent interview and record review on 1/10/2025 at 1:16 p.m., with Licensed Vocational Nurse (LVN) 3, Resident 110's care plans were reviewed. LVN 3 stated Resident 110 had a care plan indicating Resident 110 was on Anticoagulant therapy. LVN 3 stated the care plan intervention indicated to wear a med alert bracelet that tells staff that tge resident was on anticoagulant therapy. During a concurrent interview and record review on 1/10/2025 at 2:15 p.m., with LVN 3, in Resident 110's room, Resident 110 was observed. LVN 1 stated, Resident 110 was not wearing or had a bracelet indicating the resident was on anticoagulant therapy. During an interview on 1/10/2025 at 5:40 p.m., with the Director of Nursing (DON), the DON stated, all care plan interventions should be followed. The DON stated when care plans are not followed, the Resident may not receive appropriate care and services. During a review of the facility's Nurse Job Description: LVN/LPN, dated November 2018, the job description indicated care plans should be reviewed daily to ensure that appropriate care is being rendered. The job description indicated to ensure that the care plan is being followed when administering nursing care of treatment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on observation, interview, and record review the facility failed to: a. Carry out the physician's (MD 1) order for one of four sampled residents (Resident 145), who required a follow up with an orthopedic (relating to the branch of medicine dealing with the correction of deformities of bones or muscles) specialist after Resident 145 sustained a fractured (broken bone) radius (one of the bones in your forearm) and was placed in a right wrist soft cast (a removable cast used to treat a fracture or other injury) to the distal (away from the center) radius (bone closest to the wrist) bone. b. Assess one of one sampled Resident's (Resident 101) skin according to standards of practice. This deficient practice resulted in delay of care for Resident 145 and Resident 101. Resident 145 had an order placed on 11/25/2024 to follow up with the orthopedic specialist in two (2) weeks, Resident 145 was not seen by the orthopedic specialist until 1/10/2024 (46 days or 6 weeks and 4 days later), and Resident 101 who had a swollen left foot with scratches. Findings: a.During a review of Resident 145's Admission Record, the Admission Record indicated Resident 145 was originally admitted to the facility 9/27/2024 and readmitted on [DATE] with diagnoses including difficulty in walking, history of falling, and unspecified fracture of the lower end of right radius, closed (bones are broken but not shifted out of alignment) fracture with routine healing. During a review of Resident 145's Minimum Data Set (MDS, a resident assessment tool) dated 12/5/2024, the MDS indicated Resident 145 had moderate cognitive (short-term memory begins to be more affected, and the person may entirely forget recent events) impairment and required substantial/ maximal assistance (helper does more than half the effort) with eating and was dependent (helper does all of the effort) for toileting hygiene. During a review of Resident 145's Nurse's Progress Notes dated 11/25/2024 at 1:32 p.m., the Nurse's Note indicated Resident 145 was readmitted from a general acute care hospital (GACH) due to (d/t) an unwitnessed fall (fall occurred on 11/25/2024 at 1 a.m.) with the following diagnoses (Dx): right radius fracture and a urinary tract infection (UTI, a bacterial infection that affects the urinary tract, which includes the bladder, ureters, and kidneys). The Nurse's Note indicated a cast was on the right arm. During a review of Resident 145's Physician Orders, an order was placed on 11/25/2024 to follow up with ortho in 2 weeks. This order was held (suspended) on 11/29/2024 due to Resident 145 being transferred to the GACH. The physician's orders indicated the order to follow up with ortho in 2 weeks was not reentered when Resident 145 was readmitted from the GACH on 12/3/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 145's Nurse's Progress Note dated 11/25/2024 at 6:07 p.m., the nurse practitioner (NP 1) working with MD 1 was made aware of the radial fracture and a new order was input to follow up with ortho (orthopedic specialist) in 2 weeks and the social worker (SW 1, unknown) was made aware of the need for follow up. During a review of Resident 145's 72-Hour Charting Progress Note dated 12/3/2024, the Progress Note indicated Resident 145 was readmitted to the facility on [DATE] and was on monitoring for readmission. Resident 145's Nurse's Progress Notes did not mention the orthopedic specialist appointment for follow up until 1/3/2025 and an appointment was scheduled on 1/7/2025 for Resident 145 on 1/10/2025 at 2 p.m. During a review of Resident 145's Nurse's Progress Note dated 11/28/2024, the Nurse's Note indicated Resident 145 was transferred back to the GACH to treat extended-spectrum beta-lactamase (ESBL, bacteria that is resistant to antibiotics and difficult to treat) UTI. During a review of Resident 145's History and Physical (H&P) dated 12/6/2024, the H&P indicated Resident 145 was recently transferred to the GACH status post (s/p) fall (11/25/2024) resulting in a right radius fracture, ortho was consulted and a cast was placed on Resident 145's right arm. The plan of care for Resident 145 included a follow-up with ortho in 1-2 weeks. During an interview and concurrent record review on 1/9/2024 at 11:31 a.m. with the social services director (SSD) Resident 145's Physician Orders were reviewed. The SSD stated the nursing team was responsible for scheduling appointments and the social services team was responsible for setting up transportation to and from the appointments. The SSD stated the social services team would not know about any appointments unless the nursing team placed an order for an appointment and upon review of Resident 145's Physician Orders, the order placed on 11/25/2024 to follow up with ortho in 2 weeks was not reentered when Resident 145 was readmitted from the GACH on 12/3/2024. The SSD stated there was no other order for an ortho appointment until the order was placed on 1/7/2025 for an ortho appointment on 1/10/2025 at 2 p. m. During an interview on 1/9/2025 at 12 p.m., Resident 145 stated she was happy to be going to the orthopedic specialist the next day on 1/10/2025 because she had her cast on for 2 months and wanted it off because she was not able to feed herself when she could normally do everything by herself. Resident 145 stated she was right-handed and couldn't do anything, not even blow her nose. During an interview on 1/10/2025 at 10:12 a.m., registered nurse (RN 2) stated she reviewed Resident 145's electronic medical record (EMR) and there was no follow up for the orthopedic specialist documented between 11/25/2024 and 1/3/2025 when the nursing team began looking for information on the orthopedic specialist. RN 2 stated, when Resident 145 was readmitted from the GACH on 12/3/2024, the order to follow up with ortho in 2 weeks was not reconciled (the process of comparing the resident's previous orders prior to being discharge compared to orders needed upon readmission) and reentered so it was missed. RN 2 stated the potential outcome for not following physician's orders in the case of Resident 145 was a delay in care, Resident 145 was not able to see the ortho on time. RN 2 stated Resident 145 was non weight baring on the right upper extremity (RUE) until she was seen by ortho so there was a possibility she remained non weight baring for an extended amount of time and there was a possibility for muscle deterioration in the RUE. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/10/2025 at 11:20 a.m., MD 1 stated when physician's orders were placed, he expected nursing staff to carry the orders through and if they were not carried out there was a possibility for a delay in care. During a review of the Licensed Vocational Nurse (LVN) Job description dated 11/2018, the job description indicated the LVN was to requisition and arrange for diagnostic and therapeutic services, as ordered by the physician, and admit, transfer, and discharge resident's as necessary. During a review of the facility's policy and procedure (P/P) titled Admission Assessment and Follow Up: Role of Nurse dated 9/2012, the P/P indicated upon admission the nurse was to conduct an admission assessment including the resident's current treatments and contact the physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. The P/P indicated the nurse was to notify the physician of any immediate needs that the resident may have. b. During a review of Resident 101's Admission Record, the Admission Record indicated the facility admitted Resident 101 on 8/3/2017 and readmitted on [DATE] with diagnoses including atherosclerosis of native arteries (a condition where plaque [unhealthy tissue] builds up in the walls of the arteries, causing them to harden and thicken) of the left leg with ulceration (skin breakdown) of heel and midfoot, and peripheral (away from the center) vascular (blood vessel) disease (a condition that occurs when blood vessels narrow or become blocked, reducing blood flow to peripheral areas of the body.) During a review of Resident 101's Minimum Data Set (MDS-a resident assessment tool), dated 12/26/2024, the MDS indicated that Resident101's cognitive (the ability to think and process information) was moderately impaired. During a review of Resident 101's Nursing Progress Notes, dated 1/8/2024, the Nursing Progress Notes indicated that the resident was alert and oriented to person only. During a review of Resident 101's Skilled Nursing Facility (SNF) Wound Care, dated 1/9/2025, the SNF Wound Care indicated that Resident 101 had no skin issue. During a concurrent observation and interview on 1/7/2025 at 12:08 p.m. with Resident 101 in the resident's room, one fourth of the resident's foot was observed to be swollen, with scratches visible on top of the swelling. The resident was unable to explain how the injury occurred. During a concurrent observation and interview on 1/10/2025 at 8:35 a.m., with Licensed Vocational Nurse (LVN) 3 in Resident 101's room, LVN 3 stated that she was not aware of the resident's skin changes on her left foot including the swelling and the scratches. During an interview on 1/10/2025 at 1:59 p.m., with LVN 3, LVN 3 stated, staff should have assessed Resident 101's skin changes over the past few days. LVN 3 stated that Resident 101 required assistance for activities of daily living, and the Certified Nurse Assistants (CNA general) who assisted the resident did not detect the changes, also the treatment nurse performed a skin sweep (a skin check) on the resident the previous day but did not detect the skin changes. LVN 3 also stated that early detection of skin changes is critical, as changes in a resident's condition can lead to serious health consequences. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/10/2025 at 3:10 p.m. with CNA 1, CNA 1 stated that she assisted Resident 101 including changing clothes on 1/9/2025 but did not observe any skin changes at that time. During an interview on 1/10/2025 at 5:31 p.m. with the Director of Nursing (DON), the DON acknowledged that staff did not properly assess Resident 101 and stated that the resident should have been assessed appropriately. During a review of the facility's policy and procedure (P&P) titled, Job Description: Certified Nursing Assistant, dated 2/2019, the P&P indicated CNA's are required to observe and report residents' skin breakdowns. During a review of the facility's P&P titled, Job Description: Licensed Practical Nurse (LPN)/ LVN, dated 11/2018, indicated LVN required to make periodic checks to evaluate the resident's physical status. During a review of the facility's policy and procedure (P&P) titled, Pressure Ulcers/Skin Breakdown, revised 4/2018, indicated that the nursing staff will assess and document an individual's significant risk factors for developing pressure ulcers, and examine the skin of newly admitted residents of other skin conditions. 50387

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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. 45382 Based on observation, interview, and record review, the facility failed to ensure Restorative Nursing Aide 1 (RNA 1) locked one of ten sampled resident's (Resident 156) wheelchair brakes prior to assisting Resident 156 into a standing position. This deficient practice placed Resident 156 at risk for fall and injury. Findings: During a review of Resident 156's Admission Record, the Admission Record indicated the facility admitted Resident 156 on 5/5/2022 with diagnoses including Alzheimer's disease (a type of disease that affects memory, thinking, and behavior) and chronic obstructive pulmonary disease (lung disease that causes obstruction of airflow and can limit normal breathing). During a review of Resident 156's Order Summary Report, the Order Summary Report indicated a physician's order, dated 4/28/2023, for Restorative Nursing Aide (RNA, nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) to assist Resident 156 with ambulation (walking) exercises using a front wheeled walker (FWW, mobility device with two wheels in the front used for support when standing or walking), once a day, five times a week. During a review of Resident 156's Minimum Data Set (MDS, a resident assessment tool), dated 11/6/2024, the MDS indicated Resident 156 had severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 156 required partial/moderate assistance for eating, upper body dressing, rolling to both sides, substantial/maximal assistance for oral hygiene, personal hygiene, sit to stand transfers, toilet transfers, and walking, and was dependent in bathing and lower body dressing. During a review of Resident 156's Fall Risk Observation/Assessment, dated 11/6/2024, the Fall Risk Observation/Assessment indicated Resident 156 received a total score of 14, indicating Resident 156 was a moderate fall risk. During an observation on 1/8/2025 at 10:28 a.m., in Resident 156's room, Resident 156 was seated in a wheelchair. Restorative Nursing Aide 1 (RNA 1) transported Resident 156 in the wheelchair into the hallway for walking exercises. While seated in the wheelchair, Resident 156 continuously and slowly shifted the body side to side and rocked back and forth. RNA 1 placed a FWW in front of Resident 156 and assisted Resident 156 with walking exercises to the end of the hallway. At the end of the hallway, Resident 156 sat down in the wheelchair to rest. While seated, RNA 1 turned the wheelchair around to face the other direction, moved to Resident 156's right side, locked the right wheelchair brake, placed the FWW in front of Resident 156, and assisted Resident 156 into standing. RNA 1 did not lock the left wheelchair brake prior to standing Resident 156. RNA 1 assisted Resident 156 with walking exercises using a FWW down the hall and back into Resident 156's room. (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 1/8/2025 at 10:42 a.m., RNA 1 stated she did not lock both of Resident 156's wheelchair brakes before assisting Resident 156 into standing when assisting Resident 156 with walking exercises on the way back to the room. RNA 1 stated she should have locked both wheelchair brakes before standing Resident 156 for safety but did not. RNA 1 stated if both wheelchair brakes were not locked prior to standing a resident seated in a wheelchair, it could result in an accident or a fall. During an interview on 1/8/2025 at 2:08 p.m., the Director of Rehabilitation (DOR) stated both wheelchair brakes must be locked prior to standing a resident from a wheelchair. The DOR stated if both wheelchair brakes were not locked prior to standing from a wheelchair, it could result in falls, accidents, and/or the resident experiencing increased fear and anxiety from falling due to transferring from an unstable surface. During an interview on 1/10/2025 at 4:58 pm, the Director of Nursing (DON) stated both wheelchair brakes must always be locked before standing a resident from a wheelchair to prevent accidents or falls. During a review of the facility's undated Policy and Procedure (P/P), titled Transfers, the P/P indicated the objectives of the policy were to provide safety for the unsteady and confused resident, to prevent injuries to employee and residents, and to allow the resident and aide to feel more secure during the transfer. The P/P indicated one of the general principles of transferring of a resident was to lock the brakes of the wheelchair. During a review of the facility's P/P titled, Safety and Supervision of Residents, revised 7/2017, the P/P indicated the facility strived to make the environment as free from accident hazards as possible. The P&P indicated resident safety and supervision and assistance to prevent accidents were facility-wide priorities.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50387 Based on observation, interview and record review, the facility failed to: A.Dispose of needles properly in the, designated containers. B.Maintain accurate drug records, including proper documentation of signatures and dates on two narcotic (a substance used to treat moderate to severe pain) sheets. This failure had the potential to increase the risk of accidental needle sticks and drug diversion, compromising resident and staff safety. Findings: a.During a concurrent observation and interview on 1/9/2025 at 10:52 a.m., with Licensed Vocational Nurse (LVN) 2, in the medication storage area in the Villa unit, four Enoxaparin (a drug used to treat and prevent blood clots) injections with needles were inside the regular trash disposal bin. LVN2 stated, the four Enoxaparin injections were hazardous and should be disposed of in the sharp container. During an interview on 1//9/2025 at 4:15 p.m., with the Director of Nursing (DON), the DON stated that the Enoxaparin injections should be disposed of in the designated sharps container. The DON also stated that improperly disposing of needles could cause injuries. During a review of the facility's policy and procedure (P&P) titled, Sharps Disposal, dated 2001, the P&P indicated that whoever uses contaminated sharps will discard them immediately or as soon as feasible into designated containers. During a review of facility's P&P titled, Syringe and Needle Disposal, revised 1/2018, the P&P indicated that immediately after use, syringes and needles are placed into puncture resistant, one-way containers (sharps) specifically designed for that purpose. B.During a concurrent interview and record review on 1//9/2025 at 4:00 p.m., with the DON, documentation titled Endorsed Controlled Medications for Disposition, and the Controlled Medication Count Sheets (Narcotic Sheets) were reviewed. The Narcotic Sheets indicated: The DON did not sign and date the narcotic sheet upon receiving five acetaminophen-codeine (used to relieve mild to moderate pain) tablets 300 milligram (mg-a unit of measure of weight)60mg for Resident 55 from a staff, member for disposition (destroying). There was no witness signature and date documented on the narcotic sheet upon the DON receiving eighty-six Tramadol (a strong painkiller from a group of medicine called opiates, or narcotics) 50 mg tablets for Resident 133 from a staff member for disposition. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1//9/2025 at 4:00 p.m., with the DON, the DON stated that it is important to properly document the receipt of narcotics, including witness signatures, the DON's name, and the date on the narcotic sheets. The DON also stated that without proper documentation and signatures, there's a risk of medication misplacement or diversion. During a review of the facility's P&P titled, Controlled Substance Disposal, revised 1/2018, indicated that accountability records for controlled substances awaiting destructions or disposal must be stored. The P&P also indicated that the signatures of witnesses and the date of destruction to be documented in the controlled substance accountability record/book when controlled medications are destroyed at the facility.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on interview and record review, the facility failed to ensure psychotropic drugs (any medication capable of affecting the mind, emotions, and behavior) were not used unnecessarily for three of three sampled residents (Resident 205, Resident 150, and Resident 196) by failing to ensure: A. Resident 205 did not receive routine psychotropic drugs unless the medication was necessary to treat a diagnosed specific condition that was documented in the clinical record. B. To document daily monitoring for side effects for the use of Seroquel (an antipsychotic medication-used to treat disordered thinking associated with severe mental illness) and Trazodone (an anti-depressant to treat depression or anxiety) from October 16, 2024, to January 9, 2025 for Resident 150. C. Resident 196's medication was ordered appropriately for their diagnosis who was on Risperdal (medication used to treat the symptoms of schizophrenia [a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions]) for schizophrenia. These failures had the potential to result in the use of unnecessary or non-therapeutic use of psychotropic drugs and can lead to side effects and adverse (unwanted or dangerous medication side effects) consequences such as a decline in quality of life and functional capacity for Residents 205, 150 and 196. Findings: A. During a review of Resident 205's Admission Record, the Admission Record indicated, Resident 205 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (amental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 205's History and Physical (H&P), dated 11/25/2024, the H&P indicated, Resident 205 had no capacity (ability) to understand and make decisions. During a review of Resident 205's Preadmission Screening and Resident Review (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care), dated 11/25/2024, the PASARR indicated, level 1 screening was negative and specialized services were not recommended. During a review of Resident 205's Order Summary Report (OSR), dated 12/1/2024, the OSR indicated, a physician's order dated 11/22/2024; give four tablets of Lurasidone HCL Lurasidone (Latuda- a medication to treat mental illness and mood disorder) 20 milligram (mg) 80 mg by mouth two times a day for dementia with behavioral disturbance manifested by agitation leading to resisting care. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 205's Subjective, Objective, Assessment and Plan (SOAP) Note, dated 12/7/2024, the SOAP Note indicated, Resident 205 was seen for a psychiatric (a branch of medicine specializing in the diagnosis and treatment of mental health disease) consultation at the request of the primary care physician to assess Resident 205's behaviors and review any psychotropic medication. The SOAP note indicated, Dose reduction of psychotropic medication was contraindicated because the benefits of administering the Lurasidone HCL to Resident 205 outweighed the risks, and a reduction is likely to impair the resident's function and cause instability. During a review of Resident 205's Minimum Data Set (MDS - a resident assessment tool), dated 12/8/2024, the MDS indicated Resident 205 required supervision or touching assistance (Helper provides verbal cues and /or touching/steadying and /or contact guard assistance as resident completes activity) from one staff for eating, dressing, bed mobility, chair/bed to chair transfer, and maximal assistance (Helper does more than half the effort) from one staff for toilet transfer, and toileting hygiene. The MDS indicated, Resident 205 did not have any potential indicators for psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). The MDS indicated, Resident 205 did not have physical and verbal behavioral symptoms directed toward others. The MDS indicated, Resident 205 did not have behavior related to rejection of care. During a review of Resident 205's Care Plan (CP), revised on 12/19/2024, the CP Focus indicated, Resident 205 had agitation leading to resisting care related to dementia with behavioral disturbance. The CP Interventions indicated, monitor behavior episodes, and attempt to determine underlying cause and document behavior. The CP Interventions indicated, monitor and document for side effects and effectiveness. During a review of Resident 205's CP, revised on 12/19/2024, the CP Focus indicated, potential for side effects, complications or adverse reaction related to ordered antipsychotic drug Lurasidone. The CP Interventions indicated, attempt a gradual dose reduction as indicated/condition improves. During a phone interview on 1/9/2025, at 9:37 a.m., with the Facility Pharmacy Consultant (FPC), the FPC stated, Resident 205 was on Lurasidone 80 mg twice a day. The FPC stated, Lurasidone was usually prescribed to treat schizophrenia. The FPC stated, he realized that the order indicated, monitoring for 'resisting care' and it was not proper or targeting a specific behavior related to a diagnosis. The FPC stated, there was no justifiable diagnosis to prescribe Lurasidone. The FPC stated, unnecessary medications would cause side effects such as lethargy (an unusual decrease in consciousness), increased mortality (the state of being subject to death) rate in the elderly, and increased blood glucose levels (blood sugar level). During an interview on 1/9/2025, at 10:34 a.m., with Certified Nurse Assistant (CNA) 2, CNA 2 stated, Resident 205 had never resisted care and was compliant with care. CNA 2 stated, Resident 205 tried to get out of the unit sometimes to go home, but he was able to redirect him back to his room. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/9/2025, at 10:36 a.m., with Licensed Vocational Nurse (LVN) 4, Resident 205's Medication Administration Record (MAR), dated 11/1/2024 to 1/8/2025 was reviewed. The MAR indicated, to monitor behavior episodes of dementia with behavioral disturbance manifested by agitation leading to being resistive to care every shift related to Lurasidone. The MAR indicated, Resident 205 did not have any behavior episodes except one episode on 11/27/2024 and one episode on 12/9/2024. LVN 4 stated, resisting care could be anything and she was not sure what episodes of behavior that the staff were monitoring. LVN 4 stated, a resident with dementia could display similar behaviors such as resisting care. LVN 4 stated, dementia related behaviors should have been ruled out before starting an antipsychotic medication to prevent giving medications unnecessarily. LVN 4 stated, monitoring specific behavior was important to determine Resident 205's care because dose adjustment for Lurasidone depended on the number of behavior episodes. LVN 4 stated, Resident 205 was cooperative with care and compliant with taking medications. During a phone interview on 1/9/2025, at 11:56 a.m., with the Psychiatrist (medical specialty in the diagnosis and treating mental illness) Medical Doctor (PMD), the PMD stated, staff did not report to him that Resident 205 only had two episodes of resisting care from 11/2024 to 1/2025. The PMD stated, he realized Lurasidone was inappropriate for Resident 205, because, Resident 205 did not have justifiable medical diagnoses. The PMD stated 'resisting care', was not the right behavior to monitor related to Lurasidone. The PMD stated, Resident 205 should not suffer from various side effects of unnecessary medication. The PMD stated, Lurasidone would be tapered down (dosage gradually reduced) and discontinued. During a concurrent interview and record review on 1/10/2025 at 5:07 p.m., with the Director of Nursing (DON), Resident 205's Point of Care (POC) Response History, dated from 12/2024 to 1/2025 was reviewed. The POC Response History indicated, Resident 205 did not refuse any care. The DON stated, POC Response History was the same as Activity of Daily Living (ADL) flow sheet. The DON stated, there was no documentation that indicated Resident 205 resisted care. The DON stated, staff should have ensured that antipsychotic medications were ordered appropriately with proper medical diagnoses, and to monitor specific behavior related to the medical diagnoses. The DON stated, if the medications were prescribed unnecessarily, the residents would needlessly suffer from side effects and adverse reactions from the medications. B. During a review of Resident 150's's admission record, Resident 150 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), vascular dementia (a progressive state of decline in mental abilities that occurs when blood flow to the brain is reduced or blocked), depression (persistent feeling of sadness and loss of interest in activities of daily living), and anxiety (an emotional state of fear, dread and uneasiness). During a concurrent interview and record review on 1/10/2025 at 12:33 p.m., with Licensed Vocational Nurse (LVN) 3, Resident 150's order summary report dated 12/5/2024, and medication administration record (MAR) dated October 2024 to January 9, 2025, was reviewed. The report indicated: 1. Resident 150 was incapable of understanding, rights, responsibilities, and Informed consent (order date 4/10/2024) (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Seroquel Oral Tablet 100 milligrams (MG-unit of measurement) (Quetiapine Fumarate) Give 150 mg by mouth at bedtime for schizoaffective disorder manifested by (M/B) disrobing in public spaces. (Order date 3/11/2024) 3. Antipsychotic Medication (Seroquel) - Monitor for Dry mouth, constipation, blurred vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea/vomiting (n/v) lethargy, drooping, extrapyramidal symptoms (EPS - tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth or tongue). Every 8 hours as needed for if side effect (S/E) noted, document and notify MD. (Order date 8/20/2024) 4. Trazodone HCL Oral Tablet 100 mg Give 50 mg by mouth at bedtime for Depression M/B inability to sleep. (Order date 10/15/2024) 5. Anti-Depressant Medication Use (Trazodone) - Observe resident closely for significant side effects: Common - sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photosensitivity (skin), excess weight gain, special attention for: heart disease, glaucoma, chronic constipation, seizure disorder, edema. Every 8 hours as needed if S/E noted, document and notify MD. (Order date 8/20/2024). During a record review of Resident 150's medication administration record (MAR) for October 2024 to January 9, 2025, the MAR did not indicate that side effects or adverse effects were monitored for Resident 150. LVN 3 stated the side effect monitoring for Resident 150's Seroquel and Trazodone medication was on an as needed (PRN) basis. LVN 3 stated there is no daily or shift documentation that would indicate that side effects were monitored. LVN 3 stated facility staff should monitor side effects regularly and more than just PRN. LVN 3 stated if side effects of antipsychotic medication were not monitored appropriately, it places residents at risk for adverse side effects such as sedation, dizziness, withdrawing from activities, or falling. During an interview on 1/10/2025 at 4:22 p.m., with the PMD, the PMD stated nursing staff should be monitoring for side effects such as shakes, tremors, Tardive dyskinesia (TD- a neurological disorder characterized by involuntary movements of the face and jaw), abnormal facial movements. The PMD stated nurses should monitor residents for side effects every shift. During an interview with the Director of Nursing (DON) on 1/10/2025 5:06 p.m., the DON stated side effect monitoring was changed because staff was complaining that it was taking too long to document during medication pass, but that side effects should be checked every shift. C.During a review of Resident 196's Admission Record, the Admission Record indicated Resident 196 was admitted to the facility on [DATE], with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia, anxiety, and unspecified psychosis (a diagnosis given when there's not enough information to diagnose a specific psychotic disorder). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 196's MDS, dated [DATE], the MDS indicated Resident 196 was moderately cognitively impaired for daily decision-making and needed set up or clean up assistance (helper sets up or cleans up, resident completes the activity but helper assist only prior to or following the activity) for functional abilities such as eating, oral hygiene, upper body dressing and needed supervision or touch assistance (helper provides verbal cue and/or touching and/or contact guard assistance) with toileting, shower/bathe, lower body dressing and personal hygiene. The MDS also indicated Resident 196 needed assistance with sit to lying, lying to sitting on side of bed and sit to stand position. During a review of Resident 196's Order Summary Report, the Order Summary Report indicated Risperdal (Risperidone a medication used to treat mental disorders) oral tablet 2 mg give 1 tablet by mouth two times a day for unspecified schizophrenia manifested by disorganized thinking ordered on 11/25/2024. During a review of Resident 196's Order Summary Report, the Order Summary Report indicated to monitor for episodes or behavior of schizophrenia disorganized thinking every shift for Risperdal use ordered on 12/12/2024. The Order Summary Report indicated to observe, monitor and report side effects of anti-psychotic agent Risperdal. Chart 0 for none or use 1st letter of TCAP, T=tardive dyskinesia (facial, tongue movement), C=cognitive impairment (decreased mental status), A=akathisia (inability to sit still), P=parkinsonism (tremors, drooling, rigidity) every 8 hours as needed ordered on 9/20/2024. During a review of Resident 196's facility verification of informed consent dated 11/25/2024, indicated psychoactive medication Risperdal 2 mg by mouth two times a day related to unspecified psychosis. During a record review of Resident 196's Comprehensive Care Plan, dated 9/20/2024, the Comprehensive Care Plan indicated Resident 196 will be/remain free of psychotropic drug related complications including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through the review date and will reduce the use of psychotropic medication through the review date. The interventions/tasks were to monitor/record occurrence of for target behavior symptoms of unspecified psychosis not due to a substance or known physiological condition manifested by disorganized thinking and document. During an observation on 1/7/2025 at 11:38 a.m., in Resident 196's room, Resident 196 stated she was taking a medication for mood stabilizer and knew what medication she was taking for her mood. During a concurrent interview and record review on 1/10/2025 at 1:03 p.m., with LVN 3, a psychiatric consultation note dated 11/22/2024 was reviewed. The psychiatric consultation note indicated Resident 196 had a history of anxiety disorder, depression, dementia, and psychosis. The psychiatric consultation notes indicated the diagnoses attached to this encounter visit was anxiety disorder, major depressive disorder, unspecified dementia, and unspecified psychosis. LVN 3 stated that the consent and doctor's orders should match when ordered and carried out. LVN 3 stated Resident 196 was receiving the medication Risperdal before, and it was prescribed for her unspecified psychosis but does not know why the medication was ordered for schizophrenia this time. LVN 3 stated there was nothing on the psychiatric consultation note indicating Resident 196 had a new diagnosis of schizophrenia. LVN 3 stated she does not know why it was ordered for unspecified schizophrenia if Resident 196 does not have a diagnosis of schizophrenia. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 1/10/2025 at 4:22 p.m., with the PMD, the PMD stated Risperdal was ordered short term for Resident 196 to help with behaviors and disorganized thinking. The PMD stated it the Risperdal was being tapered down from 2 mg to 1 mg, and it would be discontinued. During an interview on 1/10/2025 at 5:06 p.m., with the Director of Nursing (DON), the DON stated the order was input incorrectly. DON stated Resident 196 was diagnose with unspecified psychosis and the medication was ordered for short term use for her unspecified psychosis. DON stated residents that have dementia should not be on antipsychotic medication. During a review of the facility's Policy and Procedure (P&P) titled, Antipsychotic Medication Use, dated 2001, the P&P indicated, Policy Statement: Residents will not receive medications that are not clinically indicated to treat a specific condition . Policy Interpretation and Implementation: 1. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 2. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others . 4. The attending physician and facility staff will identify acute psychiatric episodes and will differentiate them from enduring psychiatric conditions. 5. Residents who are admitted from the community or transferred from a hospital and who are already receiving anti-psychotic medications will be evaluated for the appropriateness and indications for use . 6. Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident . 12. Anti psychotic medications will not be used if the only symptoms are one or more of the following: a. Wandering; b. Poor self-care; c. Restlessness; d. Impaired memory; e. Mild anxiety; f. Insomnia; g. Inattention or indifference to surroundings; h. Sadness or crying alone that is not related to depression or other psychiatric disorders; i. Fidgeting; j. Nervousness; or k. Uncooperativeness .20. The physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. During a review of the facility's Policy and Procedure (P&P) titled, Medication Therapy, reviewed 5/2024, the P&P indicated, Policy Statement: 1. Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. 2. Medication use shall be consistent with an individual's condition, prognosis, values, wishes, and responses to such treatments . Policy Interpretation and Implementation . 4. Periodically, and when circumstances are present that represent a greater risk for medication-related complications, the staff and practitioner will review the medication regimen for continued indications, proper dosage and duration, and possible adverse consequences. 5. The physician will identify situations where medications should be tapered, discontinued, or changed to another medication, for example: a. when a medication is being given in excessive doses, for excessive periods of time, without adequate monitoring, or in the absence of a valid clinical rationale; b. when the results of ongoing assessment, or the presence of clinically significant adverse consequences monitoring, suggest that a medication should be reduced or discontinued entirely 6. The consultant pharmacist shall review each resident's medication regimen monthly, as requested by the staff or practitioner, or when a clinically significant adverse consequence is confirmed or suspected. 7. The facility shall review medication-related issues as part of its quality assurance and performance improvement committee and activities. 50144

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50387 Based on observation, interview and record review, the facility failed to properly label a tuberculosis (TB-bacterial infection that usually affects the lungs but can spread to other parts of the body) purified protein derivative (PPD a skin test used to check if someone has been exposed to tuberculosis bacteria) vial and a Rybelsus (a medication for diabetes [the body's inability to process sugar]) bottle with the open dates. This failure has the potential to increase the risk of using compromised or ineffective medications. Findings: During a concurrent observation and interview on 1/9/2025 at 10:52 a.m., with Licensed Vocational Nurse (LVN)1, in the Villa unit, one TB PPD vial observed did not have an open date. LVN 1 stated the vial should have been labeled with the open date. During a concurrent observation and interview on 1/9/2025 at 3:16 p.m., with LVN 2, in the Terrace unit, one bottle of Rybelsus did not have an open date. LVN 2 stated that accurate labeling with an open date is necessary to ensure medications are used before they expire. The LVN 2 stated that administering expired medications, such as Rybelsus, could result in less effective blood sugar control and reduced medication efficacy, potentially leading to adverse effects on the resident's health. During an interview on 1/9/2025 at 4:00 p.m. with the Director of Nursing (DON), the DON stated that medications should have the open date labeled directly on the medication bottle, to ensure they are used within the appropriate period. The DON stated that failure to label the open date on the bottle, or vial can lead to compromised medication efficacy. The DON stated the TB medication if used outside the recommended period, can result in inaccurate TB test readings, potentially impacting diagnosis, and treatment. The DON stated if the Rybelsus is used outside the proper period, it may lead to ineffective blood sugar control compromising the resident's diabetes management. During a review of the facility's policy and procedure (P&P) titled, Vials and Ampules of injectable medications, revised 1/2018, indicated it's important to record open date and triggered expiration date on multidose vials. The dated opened and triggered expiration date should be recorded on a label to the vial.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45891 Based on observation, interview, and record review, the facility failed to ensure one unopened box with 24 croissants which had one croissant with a dime (coin currency) sized fuzzy greenish appearing spot indicating spoilage, kept in the dry storage area, was labeled and dated for not to be stored beyound the expiration date to prevent growth of microorganisms (an organism that cannot be seen with the naked eye) that could cause food borne illness (food poisoning: any illness resulting from food spoilage or contaminated food, illness causing organisms) to the residents. These deficient practices had the potential to result in pathogen (germ) exposure and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting (uncontrolled ejection of food from the mouth) and diarrhea (loose, watery stool). Findings: During an observation on 1/7/2025 at 8:31 a.m., with the dietary director (DD), the dry storage area contained a brown box covered in clear plastic with croissants inside, the unopened box was not labeled with a use by date of 10/27/2024. The box contained one croissant that had a dime sized greenish fuzzy area on it. During an interview on 1/7/2025 at 8:34 a.m., the DD stated the unopened box of croissants was not dated and the croissants were only good for seven days. The DD stated all food stored in the facility kitchen needed to be labeled and dated. The DD stated the croissant had a green area on it that appeared to be mold (greenish growth on spoiled or decayed area). During an interview on 1/10/2025 at 2:46 p.m., the DD stated it was important to ensure all food was labeled and dated to know when the food needed to be served by and the potential outcome of serving food past the use by date (the last recommended day to eat a product while it's at its best quality) was the food was bad (inedible). During a review of the facility's policy and procedure (P/P) titled Labeling and Dating Foods dated 2023, the P/P all food items in the storeroom, refrigerator, and freezer need to be labeled and dated. During A review of the 2022 U.S. Food and Drug Administration (FDA, a United States government agency that regulates the safety of food, drugs, medical devices, and other products) food Code, Code # 3-701.11 Discarding or Reconditioning Unsafe, adulterated (food that has been intentionally changed to make it appear better, cheaper, or more valuable), or Contaminated Food. (A) A food that is unsafe, adulterated, or not honestly presented as specified under S 3-101.11 shall be discarded or reconditioned according to an approved procedure.

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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** 45382 Based on observation, interview, and record review, the facility failed to ensure Restorative Nursing Aide (RNA, nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) services provided were accurately documented for five of thirteen sampled residents (Residents 1, 21, 23, and 80). a. For Resident 1, the RNA Documentation Survey Report (RNA flowsheet, daily record of RNA services provided for each month) task did not match the RNA order and PT discharge recommendations on 9/20/2024. b. For Resident 21, the RNA flowsheet task had missing documentation for services on 8/8/2024, 8/15/2024, 8/27/2024 and 9/2/2024. c. For Resident 23, the RNA flowsheet task was not resolved (discontinued) when RNA services were discontinued. d. [Insert Corey's write up, Resident #80] These deficient practices had the potential to negatively impact the provision of necessary care and services and portray an inaccurate reflection of services provided. Findings: a. During a review of Resident 1's Admission Record, the Admission Record indicated the facility readmitted Resident 1 on 9/5/2024 with diagnoses including left-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body), contractures (loss of motion of a joint associated with stiffness and joint deformity) of the right hand and both knees, and muscle weakness. During a review of Resident 1's Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) Discharge Summary, dated 9/20/2024, the PT Discharge Summary recommendation indicated an RNA program for application of splints to Resident 1's both knees, two to four hours a day, three times a week. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated a physician's order, dated 9/20/2024, for RNA (general) to apply splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) to Resident 1's both knees for two to four hours a day, three times a week. During a review of Resident 1's October 2024 RNA flowsheet, the RNA flowsheet indicated an RNA task for RNA to apply splints to Resident 1's both knees for 30 minutes to three to five hours a day, five times a week. (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 1's Minimum Data Set (MDS, a resident assessment tool), dated 11/7/2024, the MDS indicated Resident 1 had unclear speech and severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 1 required substantial/maximal assistance in rolling to both sides and was dependent in eating, oral hygiene, bathing, dressing, and transfers. The MDS indicated Resident 1 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm (shoulder, elbow, wrist, hand) and both legs (hip, knee, ankle, foot). During an observation and interview on 1/7/2025 at 9:50 a.m., in Resident 1's room, Resident 1 was side lying in bed facing the window on the right side of the room with a blanket covering both legs. Restorative Nursing Aide 2 (RNA 2) entered Resident 1's room to remove Resident 1's blanket. Resident 1's both hips and knees were bent and rotated to the right side of Resident 1's body. Resident 1 did not move both hips, knees, and ankles when asked. Resident 1 used the left arm to pull the right arm from underneath the body. Resident 1 used the left arm to try to move the right shoulder, elbow, wrist, and hand and was unable to actively move the arm independently when asked. RNA 2 stated Resident 1 was unable to move the right arm and had contractures of both knees. RNA 2 tried to straighten Resident 1's both knees but stopped when Resident 1 became agitated. During a concurrent interview and record review on 1/10/2025 at 10:06 a.m., the Director of Rehabilitation (DOR) stated the Rehabilitation Department (Rehab) recommended and created the RNA program based on a resident's capabilities and needs to maintain his or her current level of function. The DOR stated the licensed therapist determined a resident's splinting needs along with the splint wear time (length of time and frequency a person can tolerate wearing the splint for safety, comfort, and maximal benefits) and wrote specific orders for RNA to carry out to ensure the resident was able to safely tolerate the splints. The DOR stated the licensed therapist was responsible for creating the RNA program and entering the RNA order, RNA task, and RNA frequency once an RNA program was established and implemented. The DOR reviewed Resident 1's PT Discharge Summary, dated 9/20/2024, and confirmed PT recommended RNA to apply splints to Resident 1's both knees for two to four hours a day, three times a week. The DOR reviewed Resident 1's physician's orders and confirmed Resident 1 had a physician's order for RNA to apply splints to Resident 1's both knees for two to four hours a day, three times a week. The DOR reviewed Resident 1's October 2024 RNA flowsheet and confirmed Resident 1 had an RNA task for RNA to apply splints to Resident 1's both knees for 30 minutes to three to five hours a day, five times a week. The DOR confirmed the PT discharge recommendations, RNA physicians order, RNA task, and RNA frequency did not match. The DOR stated it was important the therapy recommendations, physicians order, RNA task, and frequency matched because it could result in an inappropriate provision of recommended services if the documentation was inaccurate. The DOR stated it especially important for RNA recommendations and RNA orders involving splinting wear time and frequency to be accurate as recommended by the licensed therapist because if it was inaccurate, it could result in splint application out of the recommended parameters which could lead to skin breakdown, skin irritation, and increased resident agitation. (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 1/10/2025 at 3:49 p.m., the Director of Staff Development (DSD) stated she supervised all the RNAs. The DSD reviewed Resident 1's PT Discharge Summary, dated 9/20/2024, and confirmed PT recommended RNA to apply splints to Resident 1's both knees for two to four hours a day, three times a week. The DSD reviewed Resident 1's physician's orders and confirmed Resident 1 had a physician's order for RNA to apply splints to Resident 1's both knees for two to four hours a day, three times a week. The DSD reviewed Resident 1's October 2024 RNA flowsheet and confirmed Resident 1 had an RNA task for RNA to apply splints to Resident 1's both knees for 30 minutes to three to five hours a day, five times a week. The DSD confirmed the PT discharge recommendations, RNA physicians order, RNA task, and RNA frequency did not match. The DSD stated if the therapy recommendations, physicians order, RNA task, and frequency did not match and was inaccurately documented, it could cause confusion and inappropriate provision of services. During an interview on 1/10/2025 at 4:58 pm, the Director of Nursing (DON) stated documentation must always be accurate to prevent misinformation and confusion and to ensure the appropriate care and services were being provided. b. During a review of Resident 21's Admission Record, the Admission Record indicated Resident 21 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paraplegia (loss of movement and/or sensation, to some degree, of the legs), anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and muscle weakness. During a review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 21 was cognitively moderately impaired. The MDS indicated Resident 21 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity) with self-care abilities such as eating, moderate assistance (helper does less than half the effort. helper lifts, hold or supports trunk or limbs but provides less than half the effort) with oral hygiene and was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting, shower/bathe, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 21 needed supervision with mobility such as rolling left and right, sit to lying position, lying to sitting on side of bed and chair/bed to chair transfer and was maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with toilet and shower transfer. During a review of Resident 21's Order Summary Report, the Order Summary Report indicated RNA program for passive range of motion ([PROM], range of motion exercises that involve a helper moving a person's joint through its range of motion) exercises to both lower extremities ([BLE], both lower limbs) every day five times a week or as tolerated. During a review of Resident 21's Documentation Survey Report for RNA Program (RNA flowsheet task) for August 2024, the document indicated Resident 21 was receiving RNA services of BLE PROM every day five times a week or as tolerated, there was missing documentation of services on 8/9/2024, 8/15/2024 and 8/27/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During review of Resident 21's Documentation Survey Report for RNA Program (RNA flowsheet task) for September 2024, the document indicated Resident 21 was receiving RNA services of BLE PROM every day five times a week or as tolerated, there was missing documentation of services on 9/2/2024. During a concurrent interview and record review on 1/10/2025 with RNA 3, the Documentation Survey Reports for RNA Program for August 2024 and September 2024 were reviewed. RNA 3 stated RNA services were provided for Resident 21 but were not documented. RNA 3 stated if there was no documentation, the services was not provided for this resident, and not providing the services was not following medical doctor's orders. c. During a review of Resident 23's Admission Record, the Admission Record indicated the facility initially admitted Resident 23 on 1/27/2012 and readmitted Resident 23 on 11/22/2024 with diagnoses including Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement) and muscle weakness. During a review of Resident 23's Census List (record of hospitalization s, room changes, and payer source changes), the Census List indicated Resident 23 was transferred to the hospital on 9/17/2024 and returned to the facility on [DATE]. During a review of Resident 23's Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Discharge Summary, dated 3/12/2024, the OT Discharge Summary recommendation indicated for RNA to provide PROM exercises to both Resident 1's arms followed by the application of a carrot splint (a device that opens the hand and positions the fingers away from the palm to protect the skin from moisture, pressure, and nail puncture) to the left hand, five times a week, for up to one hour or as tolerated. During a review of Resident 23's Order Summary Report, the Order Summary Report indicated a physician's order, dated 3/12/2024, for RNA to perform PROM exercises to both of Resident 23's arms and apply a carrot splint to Resident 23's left hand, five times a week, for up to one hour or as tolerated. During a review of Resident 23's September 2024 RNA flowsheet, the RNA flowsheet indicated an RNA task for RNA to perform PROM exercises to both of Resident 23's arms and apply a carrot splint to Resident 23's left hand, three times a week, for up to one hour or as tolerated. The squares on the RNA flowsheet were blank on the following days: 9/18/2024, 9/19/2024, 9/20/2024, 9/23/2024, 9/24/2024, 9/25/2024, 9/27/2024, and 9/30/2024. During an observation on 1/10/2025 at 9:25 a.m., Resident 23 was lying in bed with blankets covering the body from the shoulders down to the feet. RNA 2 removed Resident 23's blanket. Resident 23's both hands were held in tight fists. Resident 23 opened the right hand but was unable to fully straighten all the fingers. Resident 23 did not open the left hand when asked and was unable to actively move the left wrist, elbow, and shoulder. (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 1/10/2025 at 10:06 a.m., the DOR reviewed Resident 23's September 2024 RNA flowsheet, Census List, therapy notes, and physician orders. The DOR confirmed Resident 23 had OT recommendations, a physician's order (dated 3/12/2024), and an RNA task for RNA to perform PROM exercises to both of Resident 23's arms followed by the application of a carrot splint to Resident 23's left hand, five times a week, for up to one hour. The DOR confirmed the squares on the RNA flowsheet were blank on the following days: 9/18/2024, 9/19/2024, 9/20/2024, 9/23/2024, 9/24/2024, 9/25/2024, 9/27/2024, and 9/30/2024 which indicated RNA services were not provided those days as ordered. The DOR reviewed Resident 1's Census List and confirmed Resident 1 was transferred to the hospital on 9/17/2024 and returned to the facility on [DATE] but the RNA flowsheet did not reflect Resident 1 was not in the facility since the RNA task remained active. The DOR stated RNA services were verbally discontinued upon Resident 1's re-admission to the facility on [DATE] since Resident 1 was being evaluated and treated by Rehab but the RNA task was never discontinued in the electronic clinical record. The DOR stated the active RNA task in conjunction with the blank squares inaccurately reflected the RNA services provided since it appeared as though Resident 1 missed multiple RNA sessions but did not. The DOR stated the RNA task should have been resolved when RNA services were discontinued and/or left the facility but was not. The DOR stated inaccurate documentation could cause confusion and an inaccurate reflection of the services provided. During a concurrent interview and record review on 1/10/2025 at 3:49 p.m., the DSD stated she supervised all the RNAs. The DSD reviewed Resident 23's September 2024 RNA flowsheet, Census List, and physician orders. The DSD confirmed Resident 23 had a physician's order, dated 3/12/2024, and an RNA task for RNA to perform PROM exercises to both of Resident 23's arms followed by the application of a carrot splint to Resident 23's left hand, five times a week, for up to one hour. The DSD confirmed the squares on the RNA flowsheet were blank on the following days: 9/18/2024, 9/19/2024, 9/20/2024, 9/23/2024, 9/24/2024, 9/25/2024, 9/27/2024, and 9/30/2024 which indicated RNA services were not provided those days as ordered. The DSD reviewed Resident 23's Census List and confirmed Resident 23 was transferred to the hospital on 9/17/2024 and returned to the facility on [DATE] but the RNA flowsheet did not reflect Resident 23 was not in the facility since the RNA task remained active. The DSD stated she was not aware RNA services were discontinued upon Resident 1's re-admission to the hospital on 9/23/2024 since the RNA task remained active. The DSD stated that if RNA services were discontinued or the resident left the facility, the RNA task must also be resolved because the RNA flowsheet would inaccurately appear as though RNA should be providing RNA services five times a week and that Resident 1 missed multiple RNA treatment but did not. The DSD stated inaccurate documentation could cause confusion and inappropriate provision of services. During an interview on 1/10/2025 at 4:58 pm, the Director of Nursing (DON) stated documentation must always be accurate to prevent misinformation and confusion and to ensure the appropriate care and services were being provided. d.During a review of Resident 80's Admission Records, the Admission Record indicated Resident 80 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), and muscle weakness. During a review of Resident 80's history and physical (H/P) dated 3/5/2024, the H/P indicated Resident 80 had did not have the capacity to make decisions. (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 80's MDS, dated [DATE], the MDS indicated Resident 80 was dependent on self-care abilities such as eating, oral hygiene, toileting, shower/bathe, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS also indicated Resident 80 was dependent on mobility such as rolling left and right, sit to lying position, lying to sitting on side of bed and chair/bed to chair transfer, and tub/shower transfers. During a review of Resident 80's Order Summary Report, the Order Summary Report indicated RNA to perform BLE PROM exercises as tolerated every day five times a week or as tolerated. During a review of Resident 80's Documentation Survey Report for RNA Program (RNA flowsheet task) for September 2024, the document indicated Resident 80 was receiving RNA services of BLE PROM exercises every day five times a week or as tolerated, there was missing documentation of services on 9/2/2024. During a review of Resident 80's Documentation Survey Report for RNA Program (RNA flowsheet task) for November 2024, the document indicated Resident 80 was receiving RNA services of BLE PROM exercises every day five times a week or as tolerated, there was missing documentation of services on 11/11/2024. During a review of Resident 80's comprehensive care plan dated 2/2/2024, the comprehensive care plan indicated the focus was restorative nursing-range of motion: resident at risk for decline and/or complications with range of motion in joints, decrease mobility and movement, decreased muscle strength, decreased functional use of extremity, pain, deformity, contracture, and/or skin breakdown. Requires a restorative nursing range of motion program to lower extremities. The goal was to prevent or reduce the risk of deformity or contracture. The interventions were RNA to perform BLE PROM exercises as tolerated every day five times a week or as tolerated. During a concurrent interview and record review on 1/10/2025 at 2:59 p.m., with RNA 3, the Documentation Survey Reports for RNA Program (RNA flowsheet task) for September 2024 and November 2024 were reviewed. RNA 3 stated RNA services were provided for Resident 80 on those dates but stated had forgotten to document the services provided. RNA 3 stated if there was no documentation in the chart, it means services was not provided for this resident and there could be a decline in movement if Resident 80 was not getting the RNA services as ordered. During an interview on 1/10/2025 at 5:24 p.m., with the Director of Nursing (DON), the DON stated if RNA services were provided to the residents, it should have been documented. If the services were not documented, it means the services were not provided on those dates. During a review of the facility's policy and procedure (P/P) titled Documentation revised May 2024, indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record documentation in the medical record will be objective {not opinionated or speculative), complete, and accurate documentation of procedures and treatments will include care-specific details, including the date and time the procedure/treatment was provided; the name and title of the individual(s) who provided the care; how the resident tolerated the procedure/treatment; whether the resident refused the procedure/treatment. (continued on next page)

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	555565	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Artesia Palms Care Center	11900 E. Artesia Blvd. Artesia, CA 90701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P/P titled Restorative Nursing Services revised on July 2017, indicated residents will receive restorative nursing care as needed to help promote optimal safety and independence. 49573

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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. 46537 Based on observation, interview and record review, the facility failed to implement infection control measures by failing to ensure Licensed Vocational Nurse (LVN) 5 performed hand hygiene while she was checking lunch trays in the dining room. This failure had the potential to result in compromised infection control measures to prevent the potential spread of infection among residents, staff, and visitors. Findings: During an observation on 1/9/2025, at 12:30 p.m., in the dining room, LVN 5 was checking the residents' trays against the printed sheets of diet orders. LVN 5 adjusted her mask with bare hands. LVN 5 pulled a tray out of the lunch tray cart, and she lifted the plate cover up to check the food items on the plate without performing hand hygiene after touching her mask. LVN 5 was running her fingers through her hair then she touched the juice cups on the tray without performing hand hygiene. LVN 5 was constantly touching her face and hair while she was checking the residents' trays. During an interview on 1/9/2025, at 12:33 p.m., with LVN 5, LVN 5 stated, she should have washed or sanitized her hands after she touched her hair and adjusted her mask before she touched the residents' trays to prevent cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another) and spreading infection. During an interview on 1/10/2025, at 4:06 p.m., with the Infection Control Nurse (ICN), the ICN stated, if the staff touched a body part during the task, the staff must wash their hands to prevent cross contamination. During an interview on 1/10/2025, at 5:07 p.m., with the Director of Nursing (DON), the DON stated, all staff should perform hand hygiene before, after, and between tasks. The DON stated, hand hygiene was the first line of defense against infections. DON stated, touching the body parts or any surfaces could cause cross contamination and staff should have performed hand hygiene to protect the residents and themselves. During a review of the facility's Policy and Procedure (P&P) titled, Handwashing/Hand Hygiene, reviewed 5/2024, the P&P indicated, Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare -associated infections. Policy Interpretation and Implementation . Indications for Hand Hygiene: 1. Hand hygiene is indicated: a.immediately before touching a resident; b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal. (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 Policy and Procedure (P&P) titled, Infection Control/Preventing Cross-Contamination, undated, the P&P indicated, Policy Statement: The purpose of this policy is to prevent cross-contamination and ensure the safety and well-being of residents, staff, and visitors. Policy Interpretation and Implementation: This policy applies to all staff, providers, and visitors within the facility and pertains to all activities that could pose a risk of cross-contamination, including care giving, food preparation, laundry, and environmental cleaning .Procedure:1. Hand Hygiene-Staff must wash hands with soap and water or use an alcohol-based hand sanitizer before and after resident contact, handling food or medications, contact with bodily fluids and cleaning or handling soiled items.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50144 Based on observation, and record review the facility failed to ensure: A. 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. B. To accommodate the resident's needs and preferences for safe and unrestricted mobility using a wheelchair for one of one resident (Resident 27). This failure had the potential to hinder effective evacuation during an emergency and limit the resident's independence by obstructing the path with furniture and large items. Findings: A.During a review of the facility's Client Accommodations Analysis form, dated 7/5/2024, provided by the facility on 1/10/2025, 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 (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. B. During a review of Resident 27's Admission Record, the Admission Record indicated the facility admitted Resident 27 on 3/27/2024, and readmitted on [DATE] with diagnoses including generalized muscle weakness (you feel weak in most of your muscles throughout your body, making it harder to move or perform everyday takes), and acute osteomyelitis (a bone infection that is new or recent in onset) on left ankle and foot. During a review of Resident 27's History and Physical (H&P), dated 11/30/2024, indicated, Resident 27 had infected ulcers on left ankle. (continued on next page)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 27's Minimum Date Set (MDS-a resident assessment tool), dated 12/23/2024, indicated that Resident 27 had moderately impaired cognitive (ability to reason, understand, remember, judge, and learn). The MDS also indicated Resident 27 had impairment on one side on his lower extremity and needed a wheelchair as mobility devices, not applicable to walk 10 feet in a room, corridor, or similar space. During an observation on 1/8/2025 at 8:08 a.m. in Resident 27' room, Resident 27 was observed sitting in a wheelchair in front of the restroom in the room, surrounded by the right side of the resident's bed and the foot of another resident's bed. The shortest distance between the two beds was narrower than the width of the resident's wheelchair. Resident 27 was observed attempting to push the beds aside to exit the room, but the beds did not move. Resident 27 then extended to reach pedals under his bed but was unable to access them. During an interview on 1/8/2025 at 8:10 a.m. in Resident 27's room with Assistant Director of Nursing (ADON) 1, ADON 1 stated that he observed Resident 27 sitting in a wheelchair, attempting to push two beds aside to exit the space where he was located. ADON 1 acknowledged that the resident would struggle with ambulation and would require assistance to exit the room in an emergency. During a concurrent observation on 1/8/2025 at 8:25 a.m. with a Registered Nurse (RN) 1, the RN 1 observed attempting to push Resident 27's bed and the other bed without adjusting the pedals but was not able to move the beds. During an interview on 1/9/2025 at 4:23 p.m. with Director of Nursing (DON), the DON acknowledged that the space between the two beds was narrower than Resident's wheelchair, preventing the resident from exiting without adjusting the beds. The DON also stated that this could lead to ineffective evacuation during an emergency and limit the resident's independence. During a concurrent record review and interview on 1/9/2025 at 4:23 p.m. with the DON, the facility's policy and procedure (P&P) titled, Accommodation of Needs, revised 3/2021 reviewed. The P&P indicated that adjustments to the physical environment, such as moving furniture that may obstruct the path of a resident using a walker, should be made to accommodate individual needs and preferences. The DON acknowledged that the residents' bed placement should not obstruct mobility with a walker or wheelchair. 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.