

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555565	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Artesia Palms Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observations, interviews and record review, the facility failed to ensure: 26 residents on pureed diet (foods that do not require chewing and are easily swallowed. All food should be smooth and pureed to the consistency of pudding) received pureed textured bread a form that meets their needs and in accordance with the international Dysphagia Diet Initiative-level 4 (IDDSI -a framework made up of levels and describes food textures and drink thickness) level Four (pureed foods and extremely thick drinks) when the texture of the pureed bread was lumpy and liquid seeping out, not smooth and had small pieces of bread crust present requiring chewing before swallowing. This failure had the potential to result in meal dissatisfaction and increased choking risk for 26 out of 166 residents who received the pureed bread from the facility kitchen. Findings: During an observation of the tray line (tray line- a system of food preparation, in which trays move along an assembly line) service for lunch on 12/8/2025 at 11:52AM, the pureed bread looked lumpy, and milk floating on top while in a pan on the steam table. During the same observation and interview with [NAME] (cook2) indicaon 12/8/2025 at 11:52AM, Cook2 stated the pureed bread is bread mixed with milk and blended a little, it is like bread soaked in milk. During a concurrent interview and taste test of the pureed bread with Dietary Supervisor (DS), Registered Dietitian (RD1) and Registered Dietitian (RD2) on 12/8/2025 at 1:45PM, the pureed bread had a lumpy texture. There were small pieces of bread in the pureed bread and bread residue stayed in the mouth. DS stated the consistency of the pureed bread is not smooth and some bread stays in the mouth; DS stated the bread needs a little more blending. DS stated residents on pureed diet can have difficulty swallowing and need to drink liquid to clear the mouth. During an interview with Cook2 on 12/8/2025 at 2:00PM, cook2 stated cook 2 did not blend the bread as long as the other pureed foods. Cook2 stated the bread was mixed with milk and blended so it's soft. Cook2 stated sliced white bread was used to make the pureed bread. Cook2 stated the pureed bread is not smooth because it was not blended long time. During a review of the facility recipe titled Pureed (IDDSI Level 4) Breads, cakes, cookies, pancakes and other bread products (dated 2025) the recipe documented, puree bread on low speed adding milk gradually, the finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline documented that Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and Fork drip test.		

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for one of eight sampled residents (Resident 154). This deficient practice had the potential for a delay of care for Resident 154. Findings: During a review of Resident 154's admission Record, the admission Record documented Resident 154 was admitted to the facility 5/12/2010 with diagnoses including Parkinson's disease (a movement disorder of the nervous system that worsens over time) and quadriplegia (unable to move all four limbs). During a review of Resident 154's communication care plan dated 7/24/2025, the care plan documented Resident 154 had altered communication as evidenced by: hearing problem, problems with making self understood, no speech, problem understanding others, dementia (severe cognitive decline affecting memory, thinking, language, and problem-solving). The goal of the care plan was to ensure Resident 154's needs would be met daily. Interventions of the care plan included keeping the soft touch call light (a button is activated with a very light touch which then alerts the caregiver that assistance is needed) within reach at all times. During a review of Resident 154's Minimum Data Set (MDS, a resident assessment tool) dated 10/9/2025, the MDS documented Resident 154 was severely impaired in daily decision making and never or rarely made decisions. The MDS documented Resident 154 was dependent (helper does all of the effort) for all activities of daily living (ADLs, self-care tasks like bathing, dressing, eating, using the toilet, and moving around, essential for independence). During an observation on 12/8/2025 at 10:25 a.m., Resident 154's soft touch call light (a call light that requires minimal touch to operate) was hanging over Resident 154's tube feeding pump (a medical device that is used to deliver nutrients directly into the gastrointestinal (GI) tract of a patient who is unable to take food or liquids orally) at the side of her bed and not within reach of Resident 154. During an interview on 12/11/2025 at 11:37 a.m., the Director of Nursing (DON) stated a soft touch call light was used for residents that are not able to traditionally call for help using a regular call light. The DON stated the soft touch call light was very sensitive so when it is within resident reach it will activate at the slightest movement to indicate to the staff the resident may need assistance. The DON stated the soft touch call light hanging over the tube feeding pump defeated the purpose because it would not pick up the residents movement. The DON stated it was important to ensure call lights were within reach for safety and to ensure residents had access to assistance when needed. During a review of the facility's policy and procedure (P&P) titled Answering the Call Light dated 10/2010, the P&P documented when the resident was in bed be sure the call light was within easy reach of the resident.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure psychotropic medication (medications that affect brain activities associated with mental processes and behavior) was not used unnecessarily for one of three sampled residents (Resident 7) by failing to define and monitor resident specific, measurable target behaviors related to the use of Seroquel [an atypical antipsychotic that's used to improve mood, thoughts, and behaviors for people with schizophrenia (a mental illness that is characterized by disturbances in thought) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs)] For Resident 7. The deficient practice of failing to ensure an antipsychotic medication was used to treat a specific, diagnosed condition, and failing to monitor target behaviors related to the use of psychotropic medication increased the risk that Resident 7 could have experienced adverse effects (unwanted or dangerous medication-related side effects) related to psychotropic medication therapy, such as drowsiness, dizziness, constipation, or increased risk of fall, possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 7's admission Record, the admission Record documented, Resident 7 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 7's Psychiatric Follow up Note, dated 11/26/2025, the Psychiatric Follow up Note documented, Resident 7 had limited judgement and insight (understanding) and was oriented to person only. During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool), dated 8/27/2025, the MDS documented Resident 7 required maximal assistance (Helper does more than half the effort) from one staff for dressing, shower, moderate assistance (Helper does less than half the effort) from one staff for hygiene, and 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 bed mobility, eating, transfer. During a review of Resident 7's Order Summary Report, dated 12/10/2025, the Order Summary Report documented, give one tablet Seroquel 50 milligram (mg) by mouth at bedtime for schizoaffective disorder manifested by delusional thoughts/difficulty to redirect was ordered on 6/5/2025. During a concurrent interview and record review on 12/10/2025, at 10:38 a.m., with Registered Nurse Supervisor (RNS) 2, Resident 7's Medication Administration Record (MAR), dated from 9/2025 to 12/2025 was reviewed. The MAR documented, to monitor behavior episodes for Seroquel (antipsychotic [medication that affects the brain]) use related to schizoaffective disorder, manifested by delusional (having false or unrealistic beliefs) thoughts and difficulty to redirect. The MAR documented, Resident 7 had behavior episodes of delusional thoughts/ was difficult to redirect on 9/28/2025 (two episodes), 9/30/2025 (two episodes), 10/3/2025 (two episodes), 10/10/2025 (2 episodes), 11/1/2025 (one episode), 11/4/2025 (one episode), 11/5/2025 (one episode), 11/6/2025 (two episodes), and 11/9/2025 (one episode). RNS 2 stated, she was not sure what delusional thoughts Resident 7 had. RNS 2 stated, difficulty redirecting could be caused by dementia related behavior. RNS 2 stated, target behavior should be specific and measurable, so the psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) could refer to and consider Gradual Dose Reduction (GDR- a systematic approach to stepwise tapering of medication dosage to assess if a lower dose can effectively manage symptoms, conditions, or risks, or if the medication can be discontinued entirely). RNS 2 stated, staff should monitor specific target behaviors. During a phone interview on 12/10/2025, at 4:09 p.m., with Psychiatric Nurse Practitioner (PNP)1, PNP 1 stated, he ordered Seroquel for schizophrenia (a mental (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	illness that is characterized by disturbances in thought) manifested by paranoia (an irrational and intense distrust or suspicion of others, believing they intend to harm you, even without evidence) thoughts that people want to harm him (Resident 7). PNP 1 stated, he did not know why the staff were monitoring delusional thoughts and difficulty to redirect as target behaviors. PNP 1 stated, those are not resident specific target behaviors. PNP 1 stated, he disagreed with doing a GDR on 11/2025, because there are many behavioral episodes reported in the months of November. PNP 1 stated, he realized the staff were monitoring the wrong target behaviors. PNP 1 stated, Seroquel could be an unnecessary medication, and considered a chemical restraint (the use of medications to restrict a person's movement or freedom of action, or to control behavior, when the medication is not part of a standard treatment for their condition). PNP 1 stated the Seroquel should be tapered down as soon as possible to avoid adverse reaction (an undesired or harmful effect of a drug) and chemical restraint (the use of medications to restrict a person's movement or freedom of action, or to control behavior, when the medication is not part of a standard treatment for their condition). During an interview on 12/10/2025, at 11:25 a.m., with the Director of Nursing (DON), the DON stated, target behavior should be specific and measurable to the resident's diagnosis. The DON stated, delusional thoughts could be many things, and this should be clarified with PNP 1. The DON stated, monitoring specific target behavior was important, because GDR would be performed based on this data. The DON stated, inaccurate data would lead to delays in treatment, and the resident continuing to receive unnecessary medication. The DON stated, the resident might suffer from unnecessary side effects/adverse reactions. The DON stated, unnecessary medication could be used as chemical restraint as well. During a review of Resident 7's, Psychiatric Follow- up Notes, dated on 7/30/2025, 8/31/2025, 9/28/2025, 10/26/2025, 11/26/2026 documented by PNP 1, the Psychiatric Follow- up Notes documented, Seroquel 50 milligram (mg) at bedtime for schizophrenia manifested by paranoia thoughts that people want to harm him (Resident 7). During a review of Resident 7's, Note to Attending Prescriber for GDR, dated 11/24/2025, the Note to Attending Prescriber for GDR documented, PNP 1 responded to the GDR request by marking Disagree on 11/24/2025. During a review of Resident 7's, Order Summary Report, dated 12/10/2025, the Order Summary Report documented, monitor behavior episodes of antipsychotic use (Seroquel) related to schizoaffective disorder manifested by delusional thoughts/difficulty to redirect was ordered on 7/25/2025. During a review of the facility's Policy and Procedure (P&P) titled, Psychoactive / Psychotropic Medication Use, dated 1/2025, the P&P documented, Policy Interpretation and Implementation: 1. General Guidelines: b. Residents will only receive Psychotropic medications when necessary to treat a specifically diagnosed condition that is documented in the medical record. c. The Attending Physician and other staff will gather and document information to clarify, as possible, the resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. d. The Attending Physician will identify, evaluate, and document, with input from other disciplines and consultants as needed, medical symptoms that may warrant the use of Psychotropic medications.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure minimum data set (MDS a resident assessment tool) assessments were coded accurately for two of 35 sampled resident (Resident 2 and Resident 20). -The facility failed to ensure Resident 20 who has a diagnosis of diabetes mellitus (DM a condition where the body can not process sugar normally and may lead to poor wound healing) was coded accurately.-The facility failed to ensure Resident 2's treatment for DM was coded accurately. These failures had the potential for Resident 2 and Resident 20 not receiving an individualized plan of care based on the resident's specific needs and treatment.a.During a review of Resident 20's admission Record, the admission Record documented Resident 20 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of DM, hypertension ([HTN]-high blood pressure), and dementia (a progressive state of decline in mental abilities). During a review of Resident 20's Order Summary Report, dated 5/24/2025, the Order Summary Report documented a physician order for Novolin Flex-pen (a convenient, prefilled insulin [medication used to assist the body process sugar] delivery device) 100 unit per milliliter (u/mL, a unit of measurement) solution pen injector inject as per sliding scale (the amount of insulin to be administered changes up or down based on the individual's blood sugar) subcutaneously (under the skin) before meals and at bedtime for DM. During a review of Resident 20's MDS, dated [DATE], the MDS documented Resident 20 was severely cognitively (thinking process) impaired, and required supervision (helper provides verbal cues and/or touch assistance) with self-care abilities such as eating, hygiene, bathing and putting on clothes and required supervision with mobility such as sit to stand and transfers. The MDS did not indicate Resident 20 had an active diagnoses of DM, and was receiving insulin injections seven days a week. During a concurrent interview and record review on 12/11/2025 at 9:07 a.m., with the MDS Coordinator (MDSC), Resident 20's admission Record, Order Summary Report dated 5/24/2025, and the MDS dated [DATE] were reviewed. The MDSC stated Resident 20 had a diagnosis of DM and was receiving insulin injections seven days a week. The MDSC stated the MDS was not coded (did not indicate) Resident 20 had DM. The MDSC stated the importance of accurate MDS assessment was that DM was a major diagnosis and Resident 20 was receiving medication for the diagnosis. The MDSC stated the MDS should reflect the current medical status of the resident, it should coincide with his diagnosis and the medication he was receiving. During a concurrent interview and record review on 12/11/2025 at 11:25 a.m., with the Director of Nursing (DON), Resident 20's MDS dated [DATE] was reviewed. The DON stated the MDS assessment was an inaccurate assessment of the resident, and the coding should be accurate. The DON stated the importance of accurate MDS coding was the overall accuracy of what the resident has (diagnosis and care needs), the status of the resident and medical services provided and if it was miscoded, it did not display what the resident had. During a review of the facility's policy and procedure (P/P), titled Resident Assessments, revised January 2024, the P/P documented the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments.all persons who have completed any portions of the MDS resident assessment form must sign the document attesting to the accuracy of such information.information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations and interviews. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 2's admission Record, the admission Record documented Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including DM. During a review of Resident 2's MDS dated [DATE], the MDS documented Resident 2's cognition was severely impaired. The MDS documented Resident 2 was receiving insulin injections 7 days a week. During a review of Resident 2's Order Summary Report dated 11/16/2025 to 11/30/2025, the Order Summary Report documented an order of Jardiance (medication to regulate blood sugar levels) oral tablet 25 mg for the treatment of DM. There was no order for insulin injections. During a concurrent interview and record review on 12/11/2025 at 9:35 a.m. with the MDSC, the MDSC stated Resident 2 had a diagnosis of DM and no orders for insulin injections. The MDSC stated Resident 2 had an oral medication for the treatment of diabetes mellitus. The MDSC stated insulin was inaccurately coded on Resident 2's MDS assessment dated [DATE]. During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, revised 1/2024, the P&P documented information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews.		

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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** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of three sampled residents (Resident 10) by failing to identify triggers of trauma (a very upsetting or harmful experience that can affect a person's mind or body) and develop individualized interventions for Resident 10. These failures had the potential to result in Resident 10's needs not being met, affecting the residents' mental and physical well being. Findings: During a review of Resident 10's admission record, the admission record documented Resident 10 was admitted to the facility on [DATE] with diagnoses of post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and legal blindness (a level of visual impairment that makes it difficult to perform daily tasks, even when using regular glasses, contact lenses, medication, or surgery). The admission record documented, Resident 10 had a public guardian (a government official appointed by a court to protect and manage the personal care, finances, and living arrangements for vulnerable adults). During a review of Resident 10's, History and Physical (H&P), dated 3/26/2025, the H&P documented, Resident 10 was alert and oriented to self, place, and time. During a review of Resident 10's minimum data set (MDS a resident assessment tool), dated 9/30/2025, the MDS documented Resident 10 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, bed mobility and moderate assistance (Helper does less than half the effort) from one staff for hygiene care, shower, dressing, transfer. During a concurrent interview and record review on 12/10/2025, at 10:38 a.m., with Registered Nurse Supervisor (RNS) 2, Resident 10's Care Plan Report, revised 10/21/2025 was reviewed. The Care Plan Report Focus documented, Resident 10 was at risk for psychosocial/emotional trauma related to history of stressful events or experiences (PTSD). The Care Plan Report Goal documented, Resident 10 will express feelings of safety and security in the environment. The Care Plan Report interventions documented, the staff to help Resident 10 to identify triggers that prompt symptoms. RNS 2 stated, Resident 10's Care Plan Report did not indicate what triggers Resident 10 had. RNS 2 stated, facility staff should identify Resident 10's triggers of PTSD (instead of Resident 10 to identify her own triggers) as Care Plan Report interventions documented. RNS 2 stated, the Care Plan Report interventions were not specific to Resident 10 and did not identify what triggers Resident 10 to experience re-traumatization. RNS 2 stated, it was important to identify the triggers and implement interventions that were individualized according to Resident 10's needs to prevent re-traumatization. During a concurrent interview and record review on 12/10/2025, at 2:04 p.m., with the Social Service Director (SSD), Resident 10's Social Service Initial admission Assessment, dated 3/24/2025 was reviewed. The Social Service Initial admission Assessment documented, Resident 10 was diagnosed with PTSD related to events during homelessness. The Social Service Initial admission did not indicate documentation regarding a PTSD assessment for Resident 10. The SSD stated, Resident 10's public guardian mentioned that Resident 10 was assaulted by her ex-boyfriend. The SSD stated, Resident 10 was concerned with being out on the street, homeless. The SSD stated, the staff should have assessed and identified the triggers of PTSD and the severity of possible re-traumatization from the triggers to prevent recurrent events. The SSD stated, completing the trauma assessment was important, because the resident's care would be different according to the needs from the assessment. The SSD stated, he would refer the resident to the proper services according to the trauma assessment to prevent re-traumatization. The SSD stated, Resident 10's care (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan was not person centered because there was no proper assessment done for the trauma. During an interview on 12/11/2025, at 11:25 a.m., with the Director of Nursing (DON), the DON stated, the resident's care plan is the specific resident's plan of care, and it should be implemented as it stated. The DON stated, care plan interventions should be implemented and reevaluated. The DON stated care plan interventions were from IDT meeting and should be implemented to prevent recurrent events or problems. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 4/2023, the P&P documented, Statement: A comprehensive, person-centered care plan should include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. Interpretation and Implementation: 1. A comprehensive, person-centered care plan for the resident should be developed by the interdisciplinary team (IDT) . 6. The comprehensive, person-centered care plan should: a. Include measurable objectives and time frames; b. Describe the services that are to be furnished in an attempt to assist the resident attain or maintain that level of physical, mental, and psychosocial wellbeing.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of three sampled residents (Resident 7) related to failing to revise and update fall prevention interventions recommended during the Interdisciplinary team (IDT-a group of different experts who work together to help the residents with complex needs) meeting regarding actual fall incidents 8/6/2025 and 8/30/2025 for Resident 7. These failures had the potential to result in Resident 7 and 10's needs not being met, affecting the residents' well-being, and poor patient outcomes. Findings: During a review of Resident 7's admission Record, the admission Record documented, Resident 7 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and history of falls. During a review of Resident 7's, Psychiatric Follow up Note, dated 11/26/2025, the Psychiatric Follow up Note documented, Resident 7 had limited judgement and insight (understanding) and was oriented to person only. During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool), dated 8/27/2025, the MDS documented Resident 7 required maximal assistance (Helper does more than half the effort) from one staff for dressing, shower, moderate assistance (Helper does less than half the effort) from one staff for hygiene, and 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 bed mobility, eating, and transfers. During a concurrent interview and record review on 12/10/2025, at 10:44 a.m., with Registered Nurse Supervisor (RNS) 2, Resident 7's IDT Note, dated 8/7/2025 was reviewed. The IDT Note documented, Resident 7 was found sitting on the floor on the left side of his bed on 8/6/2025 with redness on right upper back. The IDT Note documented, IDT meeting recommended to initiate a care plan for falls, provide proper footwear, bilateral (both) landing mats, continue on falling star program (identify individuals at high risk for falls, using visual cues like yellow gowns, armbands, or door signs to alert staff for extra precautions like bed alarms, closer monitoring, and assistance requests), low bed while in bed resting. RNS 2 stated, all these IDT meeting recommended interventions should be reflected in Resident 7's care plan. During a concurrent interview and record review on 12/10/2025, at 10:50 a.m., with RNS 2, Resident 7's IDT Note, dated 9/2/2025 was reviewed. The IDT Note documented, Resident 7 was found on the floor sitting on his bottom facing the television in the dining room on 8/30/2025. The IDT Note documented, IDT meeting recommended to initiate care plan, continue falling star program for safety measures, place Resident 7 on one-to-one sitter (1:1 sitter- a dedicated staff member assigned to continuously watch a specific high-risk patient in a healthcare setting to prevent falls, self-harm, or harm to others) for safety, and encourage Resident 7 to utilize a wheelchair when tired. RNS 2 stated, all IDT recommended interventions should be reflected in Resident 7's care plan to prevent future incidents of fall. During a concurrent interview and record review on 12/10/2025, at 10:55 a.m., with RNS 2, Resident 7's Care Plan Report, initiated 8/22/2025 and revised 12/8/2025 was reviewed. The Care Plan Report Focus documented, Resident 7 was a high risk for falls. The Care Plan Report Goal documented, Resident 7 will have minimal complications related to falls to extent possible. The Care Plan Interventions documented, place the call light within reach, encourage to participate in activities, encourage to use assistive device during ambulation, evaluate medications for side effects, place floor mats, keep bed in low position, keep personal items frequently used within reach, and provide proper footwear. RNS 2 stated, the care plan interventions did not include: the falling star program, the 1:1 sitter, the wheelchair use, and initiate/revise the care plan for actual fall. RNS 2 stated, the staff should initiate or revise the care plan after the actual fall incident of 8/30/2025. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Artesia Palms Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11900 E. Artesia Blvd. Artesia, CA 90701	
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comprehensive Person-Centered, revised 4/2023, the P&P documented, Statement: A comprehensive, person-centered care plan should include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. Interpretation and Implementation include: 1. A comprehensive, person-centered care plan for the resident should be developed by the interdisciplinary team (IDT) . 6. The interdisciplinary team should review and update the care plan: a. When there has been a significant change in the resident's condition . c.At least quarterly, in conjunction with the required quarterly MDS assessment.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure monitoring orders were completed and documented as 'complete' as ordered by the physician for one of 35 sampled resident (Resident 47). This deficient practice had the potential to result in unmet medical needs and increased risk of adverse health outcomes for Resident 47. Findings: During a review of Resident 47's admission Record, the admission Record documented Resident 47 was admitted to facility on 2/25/2025 and readmitted on [DATE] with diagnoses including hypertension (high blood pressure), dysphagia (difficulty swallowing), type 2 diabetes (a condition where the body does not use insulin effectively or does not produce enough insulin leading to high blood sugar level) and a history of falling. During a review of Resident 47's Minimum Data Set (MDS- a resident assessment tool) dated 9/3/2025, the MDS documented Resident 47's cognition (ability to make decisions of daily living) was severely impaired. The MDS documented Resident 47 needed Setup or clean-up assistance or supervision for activities of daily living such as hygiene, toileting, and getting dressed. During a review of Resident 47's Order Summary Report dated 12/2/2025, the Order Summary Report documented the following orders:- Monitor for bleeding, discolored urine, black tarry (black, sticky shiny indicating blood) stools, sudden severe headache, nausea, vomiting, diarrhea, muscle joint pain, lethargy (feeling weak, tired no energy), bruising, sudden changes in mental status and/or visible signs of shortness of breath, nose bleeds due to antiplatelet (medication to prevent blood clots)- Monitor behavior, document number of episodes of target behavior (continuous calling out without cause) per shift, due to mood stabilizer (Depakote), prescribed for mood disorder manifested by continuous calling out without cause. -Monitor for signs and symptoms of hyperglycemia (high blood sugar level) for diagnosis of type 2 diabetes such as increased thirst and a dry mouth, needing to pee frequently, tiredness, blurred vision, intentional weight loss, recurrent infections such as thrush, bladder infection and skin infection and notify MD immediately every shift for hyperglycemia.-Monitor for signs or symptoms of Hypoglycemia (low blood sugar level) for diagnosis of type 2 diabetes including irritable, confused behavior, moist pale skin, shallow breathing, tremors, sweating and full bounding pulse and notify MD immediately.-Monitor/document/report to MD for signs and symptoms of dehydration (occurs when the body uses or loses more fluid than it takes in) including decreased or no urine output, concentrated urine (dark colored urine), strong odor, tenting skin (skin does not return to normal after being pinched) cracked lips, furrowed tongue (grooves or cracks on tongue's surface) new onset confusion, dizziness on sitting/standing, increased pulse (heart rate), headache, fatigue/weakness, dizziness, fever, thirst, recent sudden weight loss, dry sunken eyes every shift.-Monitor pain level every shift-Monitor vital signs (basic measurements of body's essential functions including blood pressure, temperature, pulse, respirations and oxygen level) every shift During a review of Resident 47's Medication Administration Record (MAR) for December 2, 2025, the MAR did not document the above monitoring orders were completed as ordered during the night shift from 11:00 p.m. to 7:00 a.m. During a concurrent interview and record review on 12/11/2025 at 11:30 a.m., with the Director of Nursing (DON), the DON verified the findings and stated that the monitoring orders should be carried out by the licensed nurses as ordered by the physician to prevent delays in care and delivery of appropriate interventions. During a review of the facility's policy and procedure (P&P) titled, Documentation of Medication Administration revised 12/2025, the P&P documented that the Electronic Medication Administration Record (eMAR) will be utilized to ensure accurate and timely documentation of all medication administrations and associated physician-ordered monitoring requirements. The eMAR will clearly reflect monitoring orders prescribed by the physician, including but not limited to vital sign monitoring, behavioral monitoring, and other clinically documented assessments.		

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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. Based on observation, interview, and record review, the facility failed to ensure one of five residents (Resident 37) was provided with floor mats on each side of the bed, as ordered by the physician. This failure put Resident 37 at a higher risk for injury in the event of a fall. During a review of Resident 37's admission Record, the admission record documented the facility readmitted Resident 37 on 7/23/2025, with diagnoses including muscle weakness and paranoid schizophrenia (a mental disorder characterized by delusions and auditory hallucinations). During a review of Resident 37's Minimum Data Set ([MDS] a resident assessment tool), dated 10/2/2025, the MDS documented Resident 37 had moderate cognitive (thought process) impairment and transfers were not attempted due to medical condition. During a review of Resident 37's untitled plan of care revised date 10/21/2025, the care plan documented, (resident) was at risk for falls and injuries due to risk factors: use of psychoactive (medications that affect the mind/brain) drugs, poor safety awareness, impaired mobility, psychiatric (diseases of the mind) conditions: schizophrenia Interventions included, Resident 27 was a high risk for falls with or without injuries and was on the fall prevention program. During an observation on 12/8/2025 at 10:30 a.m., Resident 37 was observed in bed with bed in low position and a floor mat on the right side of the bed, but not the left side. During an observation on 12/9/2025 at 09:31 a.m., Resident 37 was observed in bed with bed in low position and a floor mat on the right side of the bed, but not the left side. During an observation, interview, and concurrent record review with Licensed Vocational Nurse (LVN) 1 on 12/10/2025 at 8:20 a.m., Resident 37 was observed in bed with a floor mat on the right side and not the left side of the bed. LVN 1 stated Resident 3 was a fall risk. LVN 1 reviewed Resident 37's Order Summary Report. The Order Summary Report documented Resident 37 had an order dated 9/23/2025 for, bilateral (both) floor mats for safety and security. LVN 1 stated Resident 37 should have a floor mat on the left side of the bed also. LVN 1 stated the purpose of floor mats is for safety and to prevent injury. During an interview and concurrent record review with the Director of Nursing (DON), Resident 37's medical record was reviewed. The DON stated Resident 37 had an order for bilateral floor mats, and that should have been implemented right away. The DON stated not having the ordered bilateral floor mats could lead to injury related to a fall. During a review of the facility's policy and procedure (P&P) titled, Fall Prevention Program Policy and Procedure, revised 11/10/2025, the P&P documented the facility's goal is to reduce the number of falls with injury in the facility by implementing resident centered care plan interventions.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to identify and to intervene in one of three sampled residents' (Resident 10) history of trauma (a very upsetting or harmful experience that can affect a person's mind or body) and triggers which may cause re-traumatization (a person encounters a new event or stimulus that triggers them to re-experience the intense stress, emotional distress, and even flashbacks of a previous traumatic event as if it were happening again). This failure had the potential to result in Resident 10 experiencing unnecessary re-traumatization. Findings: During a review of Resident 10's admission record, the admission record documented Resident 10 was admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and legal blindness (a level of visual impairment that makes it difficult to perform daily tasks, even when using regular glasses, contact lenses, medication, or surgery). The admission record documented, Resident 10 had a public guardian (a government official appointed by a court to protect and manage the personal care, finances, and living arrangements for vulnerable adults). During a review of Resident 10's History and Physical (H&P), dated 3/26/2025, the H&P documented, Resident 10 was alert and oriented to self, place, and time. During a review of Resident 10's Minimum Data Set (MDS-a resident assessment tool), dated 9/30/2025, the MDS documented Resident 10 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, bed mobility and moderate assistance (Helper does less than half the effort) from one staff for hygiene care, shower, dressing, transfer. During a concurrent interview and record review on 12/10/2025, at 10:38 a.m., with Registered Nurse Supervisor (RNS) 2, Resident 10's Care Plan Report, revised 10/21/2025 was reviewed. The Care Plan Report Focus documented, Resident 10 was at risk for psychosocial/emotional trauma related to history of stressful events or experiences (PTSD). The Care Plan Report Goal documented, Resident 10 would express feelings of safety and security in the environment. The Care Plan Report interventions documented, the staff help Resident 10 to identify triggers that prompt symptoms. RNS 2 stated, Resident 10's Care Plan Report did not indicate what specific the triggers were for Resident 10. RNS 2 stated, the staff should identify Resident 10's triggers of PTSD. RNS 2 stated, the Care Plan Report interventions would not be individualized without identifying what might trigger Resident 10 to experience re-traumatization. RNS 2 stated, it was important to identify the triggers and implement interventions that were individualized according to Resident 10's needs to prevent re-traumatization. During a concurrent interview and record review on 12/10/2025, at 2:04 p.m., with the Social Service Director (SSD), Resident 10's Social Service Initial admission assessment dated [DATE] was reviewed. The Social Service Initial admission Assessment documented, Resident 10 was diagnosed with PTSD related to homelessness. The Social Service Initial admission did not indicate, documentation of a PTSD assessment on Resident 10. The SSD stated, Resident 10's public guardian mentioned Resident 10 was getting assaulted by her ex-boyfriend when she was homeless. The SSD stated, Resident 10 was concerned with being out on the street and homeless. The SSD stated, the staff should have assessed and identified the triggers of PTSD and the severity of possible re-traumatization from the triggers to prevent recurrent events. The SSD stated, completing the trauma assessment was important, because the resident's care would be different according to the needs from the assessment. The SSD stated, he would refer the resident to proper services according to the trauma assessment to prevent re-traumatization. During an interview on 12/11/2025, at 11:25 a.m., with the Director of Nursing (DON), the DON stated, it was important to identify (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 10's PTSD triggers to prevent re-traumatization and provide the appropriate care. The DON stated, when a resident who has PTSD as a part of their diagnoses was admitted to the facility, the SSD should assess for triggers, and history to prevent re-traumatization. The DON stated re-traumatization would harm Residents' psychosocial well-being. During a review of Resident 10's Behavioral Health Progress Note, dated 12/3/2025, the Behavioral Health Progress Note documented, Resident 10 met the criteria for PTSD. The Behavioral Health Note documented, there was no documentation regarding the triggers of PTSD, and its severity. During a review of the facility's Policy and Procedure (P&P) titled, Trauma Informed Care and Culturally Competent Care, revised 8/2025, the P&P documented, Purpose : To guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice. To address the needs of trauma survivors by minimizing triggers and/or re-traumatization. General Guidelines: 1. Traumatic events which may affect residents during their lifetime include: a. physical, sexual and emotional abuse .f. forced displacement . 3. For trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. 4. Triggers are highly individualized. Resident Assessment: 1. Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers. 2. Utilize licensed and trained clinicians who have been designated by the facility to conduct trauma assessments. Resident Care Planning: 1. Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. 2. Identify and decrease exposure to triggers that may re-traumatize the resident. 3. Recognize the relationship between past trauma and current health concerns.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 17 of 91 resident rooms' met the requirements of 80 square feet ([sq. ft.] a unit of area measurement) per residents in multi-bed resident rooms and 100 sq. ft for each single bed resident room. This deficient practice had the potential to result in inadequate provision of safe nursing care, and privacy for the residents. Findings: During a review of the facility's Client Accommodations Analysis form, provided by the facility on 12/9/2025 and revised 12/11/2025, the facility had 17 rooms that measured less than 80 sq. ft. per resident in multi-bedrooms. The residents' rooms were as follows: [NAME] East Unit. Room T1 (4 beds) 305.75 sq. ft. Room T3 (4 beds) 305.25 sq. ft. Room T8 (4 beds) 298.75 sq. ft. Room T10 (5 beds) 360.5 sq. ft. Room T12 (4 beds) 305.25 sq. ft. Room T14 (4 beds) 314.5 sq. ft. Room T15 (4 beds) 314.5 sq. ft. Room T17 (4 beds) 314.5 sq. ft. Room T18 (4 beds) 305.25 sq. ft. Room T20 (4 beds) 305.25 sq. ft. [NAME] Unit. Room T21 (4 beds) 305.25 sq. ft. Room T23 (4 beds) 314.25 sq. ft. Room T27 (4 beds) 314.25 sq. ft. Room T29 (4 beds) 314.5 sq. ft. Room T30 (4 beds) 314.5 sq. ft. Room T32 (4 beds) 314.25 sq. ft. Room T34 (4 beds) 318.25 sq. ft. During observations, from 12/8/2025 through 12/11/2025, the residents residing in these rooms had enough space to move freely inside the rooms. Each resident in the above rooms had beds and side tables with drawers. There was adequate room for the operation and use of wheelchairs, walkers, or canes. Resident room size did not affect the nursing care or privacy provided to the residents. During an interview on 12/11/2025 at 12:25 p.m., the Administrator (ADM) stated the facility was aware 17 rooms did not meet the 80 sq. ft. requirement for multi resident rooms. The ADM stated it was important to ensure each resident had enough space and the staff were able to provide resident care with enough room to move around. During a review of the facility's policy and procedure (P&P) titled, Bedrooms, revised 1/2025, the P&P documented, 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. 3. Each room is designed to provide full visual privacy for each resident and equipped for adequate nursing care.		