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	05/29/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services to one of eight sampled residents (Resident 167) with limited range of motion ([ROM] full movement potential of a joint) and mobility concerns by failing to provide passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) and to apply both hand rolls (soft roll positioned in the palm of the hand and fastened with a strap) and the right elbow extension (straightening) splint (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) from 12/25/2025 to 1/1/2026. This failure had the potential to result in a decline in ROM to both of Resident 167's arms. Findings:During a review of Resident 167's admission Record, the admission Record indicated Resident 167's diagnoses included Huntington's disease (an inherited brain disorder that affects a person's ability to control their movements, emotions, and thinking), epilepsy (abnormal electrical activity in the brain marked by sudden, recurrent episodes of loss of consciousness or uncontrolled body shaking), dementia (progressive state of decline in mental abilities), and contractures (stiffening/shortening at any joint that reduces the joint's range of motion) to the right elbow and both hands.During a review of Resident 167's Minimum Data Set ([MDS] a resident assessment tool), dated 3/13/2026, the MDS indicated Resident 167 had no speech, rarely/never expressed ideas and wants, rarely/never understood others, and was severely impaired for daily decision making. The MDS indicated Resident 167 was dependent for hygiene, upper body dressing, lower body dressing, and rolling to both sides in bed. The MDS also indicated Resident 167 had functional ROM limitations in both arms and legs.During a review of Resident 167's Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Discharge summary, dated [DATE], the OT Discharge Summary indicated the Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) provided a return demonstration of the exercises to the neck and both arms. The OT Discharge Summary indicated recommendations for RNA to place the right elbow extension splint and both hand splints. During a review of Resident 167's physician's orders, dated 1/2/2026, the physician's orders indicated for the RNA to provide PROM to both arms, five times per week as tolerated, and to apply both hand rolls and the right elbow extension splint for four to six hours as tolerated, five times per week.During an interview on 5/26/2026 at 10:14 a.m., with the Director of Rehabilitation (DOR), the DOR stated the purpose of RNA (in general) included to maintain the ROM and mobility achieved while a resident was in therapy and to prevent decline. The DOR stated the purpose of splints included maintaining or increasing ROM and preventing contractures. The DOR stated the purpose of ROM exercises included to maintain a joint's integrity, prevent stiffness, and increase ROM. During an observation on 5/26/2026 at 12:00 p.m., in the resident's room, Resident 167 was lying in bed with the right arm positioned in forearm supination (rotation of the forearm that results in the palm facing upward) and right-hand in a fist.During an observation on 5/27/2026 at 8:46 a.m., in the resident's room, Resident 167 was observed lying in bed with both elbows bent, both forearms in supination, and (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555565	A. Building B. Wing	05/29/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	both hands in a fist.During a concurrent interview and record review on 5/27/2026 at 4:14 p.m., with the DOR, Resident 167's OT Discharge summary, dated [DATE], and the physician's orders, dated 1/2/2026, were reviewed. The DOR stated the RNA program should have started upon the OT's recommendation on 12/24/2025. The DOR stated Resident 167's RNA program for PROM to both arms and application of the right elbow extension splint and both hand rolls did not start until 1/2/2026. The DOR stated Resident 167 could have potentially experienced a decline in ROM without RNA services. During a follow-up interview and record review on 5/29/2026 at 12:22 p.m., with the DOR, the DOR stated Resident 167 did not receive RNA between discharge from OT on 12/24/2025 and start of RNA on 1/2/2026. The DOR stated the DOR was on vacation during Resident 167's transition from OT to RNA. The DOR stated the therapy department designated a therapist (OT 1) to submit the physician's orders for RNA while the DOR was on vacation. The DOR stated OT 1 should have but did not input the physician's order for Resident 167's RNA program.During a concurrent interview and record review on 5/29/2026 at 12:40 p.m., with the Director of Nursing (DON), the DON reviewed Resident 167's OT Discharge summary, dated [DATE], and physician's order for RNA, dated 1/2/2026. The DON stated there was a six-day gap between when Resident 167 was discharged from OT to the start of RNA services. The DON stated Resident 167 could have potentially experienced a decline in ROM without receiving RNA for PROM and application of both hand rolls and the right elbow splint. During a review of the facility's policy and procedure (P&P) titled, Resident Mobility and Range of Motion, dated 7/2024, the P&P indicated residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM.

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	05/29/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the manufacturer's specifications (detailed documents outlining the technical requirements, performance standards, and physical characteristics of a product) of a rollator walker (four-wheeled mobility aid with a frame, handlebars, hand brakes, and a built-in seat) for one of five sampled residents for accidents (Resident 13). This failure resulted in Resident 13 experiencing a fall from the rollator walker on 5/27/2026. Findings:During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (brain damage due to a loss of oxygen to the area), type 2 diabetes mellitus ([DM] disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, and history of falling. During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (brain damage due to a loss of oxygen to the area), chronic obstructive pulmonary disease ([COPD] long-term lung disease causing difficulty in breathing), type 2 diabetes mellitus ([DM] disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, and history of falling. During a review of Resident 13's Minimum Data Set ([MDS] a resident assessment tool), dated 3/6/2026, the MDS indicated Resident 13 had clear speech, understood verbal content, and had moderately impaired cognition (ability to think, understand, learn, and remember). The MDS indicated required partial/moderate assistance (helper does less than half the effort) for rolling to both sides, transferring from lying in the bed to sitting at the side of the bed, and walking 10 feet (unit of measure). During a review of Resident 13's Nursing - Fall Risk Observation/Assessment, dated 4/14/2026, the Nursing - Fall Risk Observation/Assessment indicated Resident 13 was assessed as a moderate risk for falls. During a review of Resident 13's PT Treatment Encounter, dated 5/26/2026, the PT Treatment Encounter indicated Resident 13 required stand-by assistance ([SBA] required verbal cues without any physical assistance to perform the activity) for walking 150 feet using the four-wheeled (rollator) walker.During an observation on 5/27/2026 at 2:33 p.m. in front of the facility's Palm Terrace building, Licensed Vocational Nurse 1 (LVN 1) was observed pulling Resident 13 up from a lower position with the rollator walker underneath Resident 13. LVN 1 was observed returning Resident 13 to sit onto the seat of the rollator walker when Licensed Vocational Nurse 2 (LVN 2) arrived next to Resident 13. Resident 13 sat on the seat of the rollator walker with LVN 1 positioned behind the resident, rubbing Resident 13's back, and LVN 2 on Resident 13's left side, checking Resident 13's head. During an interview on 5/27/2026 at 2:34 p.m. with LVN 1 in front of the Palm Terrace building, LVN 1 stated Resident 13 was seated on the chair in the rollator walker and wanted to get soda in the vending machine prior to returning to Resident 13's room. LVN 1 stated she was facing Resident 13 while pushing the rollator walker toward the vending machine when the front wheels got stuck in the gap between the slabs of concrete. LVN 1 stated Resident 13 fell back while sitting in the rollator walker and used the frame of the rollator to prevent Resident 13 from falling completely to the ground. During a concurrent observation on 5/27/2026 at 2:34 p.m. while interviewing LVN 1, Resident 13 denied any dizziness and pain and stated to LVN 2 that he still wanted soda from the vending machine. Resident 13 stood and walked to the vending machine using the rollator walker to obtain a soda. LVN 2 and the Director of Nursing (DON) walked alongside Resident 13 toward the resident's room. During an interview on 5/28/2026 at 8:37 a.m. in the resident's room, Resident 13 was awake and alert while lying in bed. Resident 13's rollator walker was observed next to the bed. Resident 13 did not remember falling from the rollator on 5/27/2026.During an interview on 5/28/2026 at 8:40 a.m. with LVN 1, LVN 1 stated Resident 13 was at risk for falls and was outside on 5/27/2026. LVN 1 stated she convinced Resident 13 to return to (continued on next page)

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	05/29/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the room but wanted a soda prior to returning to the room. LVN 1 stated it was Resident 13's preference to remain seated in the rollator walker while LVN 1 pushed Resident 13 toward the vending machine prior to the fall. During an interview on 5/28/2026 at 9:13 a.m. with LVN 2, LVN 2 stated she thought Resident 13 and LVN 1 were returning to Resident 13's room (on 5/27/2026). LVN 2 walked ahead of Resident 13 and LVN 1 to open the door for them when LVN 2 heard shuffling behind her. LVN 2 stated Resident 13 was already sitting on the rollator walker seat when LVN 2 turned around and did not witness Resident 13's actual fall. LVN 2 stated Resident 13's head, back, and extremities were assessed while seated and stated Resident 13 still wanted soda from the vending machine. LVN 2 stated Resident 13 walked to the vending machine using the rollator walker and then walked to the bedroom with both LVN 2 and the DON for a full body assessment.During an interview on 5/28/2026 at 2:25 p.m. with Physical Therapist 1 (PT 1), PT 1 stated Resident 13 required SBA for transfers and to walk 150 feet using a rollator walker. PT 1 stated the facility provided Resident 13 with a rollator walker to allow Resident 13 to sit when feeling tired. PT 1 stated the rollator walker's brakes should be locked prior to sitting in the rollator walker to prevent movement since it has four wheels. During an interview on 5/28/2026 at 2:42 p.m. with PT 1, PT 1 stated the rollator walker's primary purpose was an assistive device for walking.During a review of the manufacturer's specification for Resident 13's rollator walker titled, Lightweight Rollator, the manufacturer's specification included an important safety notice which indicated, Do not have anyone push you while you are seated on the Rollator. This is a walking aid only and is not to be used as a transportation device.During a concurrent interview and review of the manufacturer's specifications for the rollator walker on 5/29/2026 at 12:04 p.m. with PT 1, PT 1 stated locking the brakes while sitting in the rollator walker was important for safety. PT 1 stated it was not safe for staff to push a resident while sitting in the rollator walker which was also indicated in the manufacturer's specifications for Resident 13's rollator walker. PT 1 stated a resident could fall forward, slip off, or fall back from the rollator walker while being pushed in the rollator walker. During a concurrent interview and review of the manufacturer's specifications for the rollator walker on 5/29/2026 at 12:40 p.m. with the DON, the DON reviewed the manufacturer's specifications for Resident 13's rollator walker and stated that the resident should not be pushed while sitting in the rollator walker since it could lead to falls and injury. During a review of the facility's policy and procedures (P&P) titled, Safety and Supervision of Resident, revised 7/2024, the P&P indicated the facility strives to make the environment as free for accident hazards as possible. The P&P indicated the facility staff shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents.

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	05/29/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide accurate and complete documentation for two of 35 sampled residents (Resident 13 and Resident 46) by failing to:a. Provide accurate documentation of Resident 13's fall which occurred while sitting in a rollator walker (four-wheeled mobility aid with a frame, handlebars, hand brakes, and a built-in seat) on 5/27/2026. b. Determine Resident 46's decision making capacity (the ability to make decisions regarding health care and related treatment choice) upon admission. These failures had the potential to prevent the facility from determining the cause of Resident 13's fall and to prevent additional falls. These failures also had the potential to prevent Resident 46 and/or the responsible party from making decisions regarding Resident 46's care. Findings: a. During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (brain damage due to a loss of oxygen to the area), chronic obstructive pulmonary disease ([COPD] long-term lung disease causing difficulty in breathing), type 2 diabetes mellitus ([DM] disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, and history of falling. During a review of Resident 13's Minimum Data Set ([MDS] a resident assessment tool), dated 3/6/2026, the MDS indicated Resident 13 had clear speech, understood verbal content, and had moderately impaired cognition (ability to think, understand, learn, and remember). The MDS indicated required partial/moderate assistance (helper does less than half the effort) for rolling to both sides, transferring from lying in the bed to sitting at the side of the bed, and walking 10 feet (unit of measure). During a review of Resident 13's PT Treatment Encounter, dated 5/26/2026, the PT Treatment Encounter indicated Resident 13 required stand-by assistance ([SBA] required verbal cues without any physical assistance to perform the activity) for walking 150 feet using the four-wheeled (rollator) walker. During an observation on 5/27/2026 at 2:33 p.m., in front of the facility's Palm Terrace building, Licensed Vocational Nurse 1 (LVN 1) was observed pulling Resident 13 up from a lower position with the rollator walker underneath Resident 13. LVN 1 was observed returning Resident 13 to sit onto the seat of the rollator walker when Licensed Vocational Nurse 2 (LVN 2) arrived next to Resident 13. Resident 13 sat on the seat of the rollator walker with LVN 1 positioned behind the resident, rubbing Resident 13's back, and LVN 2 on Resident 13's left side, checking Resident 13's head. During an interview on 5/27/2026 at 2:34 p.m., with LVN 1 in front of the Palm Terrace building, LVN 1 stated Resident 13 was seated on the chair in the rollator walker and wanted to get soda in the vending machine prior to returning to Resident 13's room. LVN 1 stated she was facing Resident 13 while pushing the rollator walker toward the vending machine when the front wheels got stuck in the gap between the slabs of concrete. LVN 1 stated Resident 13 fell back while sitting in the rollator walker and used the frame of the rollator to prevent Resident 13 from falling completely to the ground. During a concurrent observation on 5/27/2026 at 2:34 p.m. while interviewing LVN 1, Resident 13 denied any dizziness and pain and stated to LVN 2 that he still wanted soda from the vending machine. Resident 13 stood and walked to the vending machine using the rollator walker to obtain a (continued on next page)

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	05/29/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soda. LVN 2 and the Director of Nursing (DON) walked alongside Resident 13 toward the resident's room. During a review of Resident 13's Progress Note, dated 5/27/2026 timed at 2:29 p.m., by LVN 1 (unknown date and time entered), the Progress Note indicated Resident 13 had a witnessed fall outside the Palm Terrace building near the vending machine. The Progress Note indicated, During ambulation, resident lifted/picked up the walker.and became unsteady and lost balance while attempting to continue ambulating with the walker improperly positioned. The Progress Note indicated LVN 1 remained in close proximity and immediately intervened, maintaining support of the resident and safety assisting/lowering resident to the floor in a controlled manner to prevent injury. During an interview on 5/28/2026 at 8:37 a.m. , in the resident's room, Resident 13 was awake and alert while lying in bed. Resident 13's rollator walker was observed next to the bed. Resident 13 did not remember falling from the rollator on 5/27/2026. During an interview on 5/28/2026 at 8:40 a.m., with LVN 1, LVN 1 stated Resident 13 was at risk for falls and was outside on 5/27/2026. LVN 1 stated she convinced Resident 13 to return to the room but wanted a soda prior to returning to the room. LVN 1 stated it was Resident 13's preference to remain seated in the rollator walker while LVN 1 pushed Resident 13 toward the vending machine prior to the fall. LVN 1 reviewed Resident 13's Progress Note and stated the Progress Note was inaccurate. LVN 1 stated Resident 13 fell from the seat while LVN 1 was pushing the rollator walker toward the vending machine and stated the rollator walker's wheels became caught in the gap between the slabs of concrete. LVN 1 stated documentation in the medical record should be accurate. LVN 1 stated Progress Note regarding Resident 13's fall needed modification because LVN 1 felt overwhelmed while documenting. During a concurrent interview and record review on 5/29/2026 at 10:27 a.m., with the DON, Resident 13's Progress Note, dated 5/27/2026 timed at 2:29 p.m., was reviewed. The DON stated (in general) a person could more accurately explain an incident at the time of the event due to the recency of the event. The DON stated LVN 1 reported that Resident 13 had a witnessed fall when the wheel of the rollator walker was caught in the gap of the concrete which caused an imbalance. The DON stated Resident 13's Progress Note indicated Resident 13 fell while walking. The DON stated the purpose of medical records (in general) was to keep an account of what happens to a resident while in the facility. The DON stated medical records should include facts to have a full understanding of an incident for resident safety. The DON stated the purpose of documenting a resident's fall incident included recording what occurred during the time of the fall to determine how to prevent the fall in the future. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised 1/2026, the P&P indicated documentation in the medical record will be objective, complete, and accurate. b. During a review of Resident 46's admission Record, the admission Record indicated Resident 46 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). (continued on next page)

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	05/29/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 46's MDS, dated [DATE], the MDS indicated Resident 46 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating, personal and oral hygiene, and toileting, and required supervision for bathing and dressing. During a concurrent interview and record review on 5/29/2026 at 9:09 a.m., with the MDS nurse (MDSN) 1, Resident 46's History & Physical (H&P) dated 4/12/2025, H&P dated 4/22/2026, and Psychiatry (medical specialty in treating mental illness) note dated 4/15/2026 at 10:25 p.m. were reviewed. MDSN 1 stated Resident 46's H&P dated 4/12/2025 and H&P dated 4/22/2026 indicated to defer (decision making) capacity to psych. MDSN 1 stated the H&P dated 4/12/2025, the H&P dated 4/22/2026, and the psychiatry noted dated 4/15/2026 did not indicate whether Resident 46 had the capacity to make decisions or not. MDSN 1 stated Resident 46 was stable and alert and remembered things. MDSN 1 stated the facility referred to the H&P to determine if a resident (general) had the ability to make medical decisions for themselves. MDSN 1 stated if health care decision making capacity is not determined by a physician, there is a risk of not respecting the resident's preferences or potentially violating their right to make their own decisions. During a concurrent interview and record review on 5/29/2026 at 10:06 a.m., with the Social Services Director, Resident 46's H&P dated 4/12/2025, H&P dated 4/22/2026, Psychiatry note dated 4/15/2026 at 10:25 p.m., and Psychiatry note dated 4/15/2026 at 10:42 a.m. were reviewed. The SSD stated the Psychiatry note dated 4/15/2026 at 10:42 a.m. indicated that Resident 46 did not possess medical decision-making capacity was created and entered by the psychiatry provider on 5/29/2026 at 10:43 a.m. The SSD stated prior to the psychiatry note dated 4/15/2026 at 10:42 a.m. created on 5/29/2026 at 10:43 a.m., there was no documentation by the facility that indicated Resident 46's decision making capacity was determined. The SSD stated social services and nursing should have followed up when the H&P stated defer capacity to psych. The SSD stated Resident 46's health care decision making capacity should have been determined at the time of admission. During an interview on 5/29/2026 at 12:19 p.m., with the Director of Nursing (DON), the DON stated decision making capacity was determined by physicians and was document in the H&P at the time of admission. The DON stated if decision making capacity was not determine by the physician, there is a potential for a delay of care. The DON stated the decision making capacity should be determined and documented on the H&P as soon as possible after the resident is admitted . During a review of the facility's P&P, titled Decision Making Capacity, revised March 2026, the P&P indicated The physician (or licensed mental health provider – psychiatrist, psychologist) will determine the resident's capacity to consent to medical care upon admission. During a review of the facility's P&P, titled Charting and Documentation, revised January 2026, the P&P indicated Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.