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	11/12/2021

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42200 Based on interview and record review, the facility failed to revise and individualize a careplan for one of one sampled resident (Resident 1) who was assessed as needing stand by assistance from staff while ambulating. This deficient practice resulted in a missed intervention implemented by staff for resident who was at risk for falls. Findings: During a review of Resident 1's Admission Record, the Admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (progressive disease that destroys memory and other important mental functions), history of falling, muscle weakness, abnormalities of gait (person's manner of walking) and mobility (ability to move). During a review of Resident 1's Minimum Data Set (MDS, a comprehensive standardized assessment and care screening tool) dated 9/29/2020, the MDS indicated Resident 1 had severely impaired cognitive (thought process) skills for daily decision-making. The MDS indicated Resident 1 required extensive assistance for dressing and personal hygiene and had two or more falls with minor injury (skin tears, abrasions, lacerations, hematomas and sprains). During a review of Resident 1's Fall Risk assessment dated [DATE], the Fall Assessment indicated Resident 1 had a score of 8 which was a moderate risk for falls. During an interview on 11/30/2020 at 4:33 p.m., and on 12/3/2020 at 4:24 p.m., Certified Nurse Assistant 1 (CNA 1) stated Resident 1 would mostly be in his room and that she did not assist Resident 1 to get out of bed or while ambulating in his room. During an interview on 12/3/2020 at 4:44 p.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 was very confused. LVN 1 stated the resident was not safe to get up and walk by himself. LVN 1 stated Resident 1 needed to be reoriented and redirected back to bed multiple times during the shift because he kept getting out of bed without assistance. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Physical Therapy (PT) Evaluation and plan treatment dated 9/22/2020, the PT Evaluation indicated Resident 1 had new onset of decrease in strength, functional mobility, reduced ability to safely ambulate, a reduced functional tolerance and decreased coordination and cognitive deficits. The evaluation indicated Resident 1 was referred to PT status post (after) fall on 9/20/2020. During an interview and concurrent record review of Resident 1's PT Discharge Summary dated 10/5/2020, the Director of Rehabilitation (DOR) stated Resident 1 was able to ambulate with stand by assist. DOR stated staff should be next to Resident 1 when ambulating for safety. DOR stated training for the nursing staff was provided for safety precautions, fall prevention and recovery techniques to decrease risk for falls. During a review of Resident 1's Fall Scene Investigation Report dated 10/7/2020, the Investigation report indicated Resident 1 had an unwitnessed fall while ambulating. The investigation report indicated the factors observed at time of Resident 1's fall was that the resident lost his balance, and the resident was alone and unattended at time of the fall. During an interview on 3/4/21 at 4:50 p.m., the Director of Nursing (DON) stated Resident 1 had several factors that made him a high risk for falls including impaired memory, exit seeking behavior, and the use of psychotropic (relating to drugs that affect a person's mental state) medication. The DON stated Resident 1's care plan did not include stand by assistance while ambulating. During a review of Resident 1's general acute care hospital (GACH) Discharge Summary, the Discharge Summary indicated Resident 1 was seen in the GACH and diagnosed with hematoma (collection of blood) of the frontal scalp and nasal (nose) bone fracture (broken bone) and was discharged from the GACH on 10/7/2020. During a review of the facility's policy and procedure (P/P) titled, Fall Management Program, the P/P indicated the facility must review falls, evaluate cause, determine additional strategies as needed to prevent recurrence for each resident and further revise the care plan if needed.

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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 0689 Level of Harm - 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** 42200 Based on interview and record review, the facility failed to ensure adequate supervision was provided for one of one sampled resident (Resident 1). A physical therapist ([PT 1], a licensed medical professional with experience in diagnosing physical abnormalities, restoring physical function and mobility, maintaining physical function and promote physical activity and proper function), recommended for Resident 1 to have more supervision (stand by assist [close supervision]) due to a new onset of a decrease in functional mobility after a fall (9/20/2020). Resident 1 had another fall after walking unsupervised on 10/7/2020 without a stand-by assist and sustained injuries. This deficient practice resulted in Resident 1 having a second fall and sustaining a scalp hematoma (collection of blood) and a nasal (nose) fracture (broken bone), requiring a transfer to a general acute care hospital (GACH) and being closely monitored in intensive care (ICU). Findings: During a review of Resident 1's Admission record, the Admission record indicated Resident 1 was admitted on [DATE] with diagnoses including Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), muscle weakness with abnormalities of gait (person's manner of walking), and a history of falls. During a review of Resident 1's Care plan for high risk for falls and injuries dated 1/2/2020, the care plan indicated the facility should anticipate and meet the resident's needs. During a review of Resident 1's Minimum Data Set (MDS), a comprehensive standardized assessment and care-screening tool, dated 9/29/2020, the MDS indicated Resident 1 had severely impaired cognitive skills (thought process) for daily decision-making. The MDS indicated Resident 1 required limited assistance (resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight bearing assistance) for bed mobility (how resident moves to and from lying position, turns side to side and positions body while in bed) and toilet use, extensive assistance (resident involved in activity; staff provide weight-bearing support) for dressing and personal hygiene. According to the MDS, Resident 1 had two or more falls with minor injuries such as skin tears, abrasions, lacerations, hematomas, and sprains. During a review of Resident 1's Fall Risk Assessment, dated 9/20/2020, the Fall Assessment indicated Resident 1 had a score of 8 which was a moderate risk for fall (16-26 is high risk; 6-15 is moderate risk; 1-5 is low risk). During a review of Resident 1's care plan, dated 9/20/2020 indicated the resident had a fall and was found on the floor next to his bed and sustained a laceration (deep cut) over the right eyebrow. During a review of Resident 1's Oder Summary report for the month of 9/2020, there was a physician order to cleanse the eyebrow laceration measuring 0.5 centimeter (cm) by 0.5 cm with normal saline (a mixture of salt and water), pat dry, apply triple antibiotic ointment (used to treat infections) and leave open to air for 14 days. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Physical Therapy (PT) Evaluation and treatment plan, dated 9/22/2020, the PT Evaluation indicated Resident 1 had a new onset of decrease in strength, functional mobility, reduced ability to safely ambulate, reduced functional tolerance, decreased coordination (the ability to use different parts of the body together smoothly and efficiently), and cognitive (thought process) deficits. The PT note indicated Resident 1 was referred to PT after a fall on 9/20/2020 with injury. During an interview and concurrent review of Resident 1's PT Discharge Summary note, dated 10/5/2020, the Director of Rehabilitation (DOR), stated Resident 1 was able to walk with stand by assist and staff should be next to the resident when ambulating for safety and supervision. The DOR stated training of the nursing staff was provided for safety precautions, fall prevention, and recovery techniques to decrease the risk for falls for Resident 1. During a review of Resident 1's Fall Scene Investigation Report, dated 10/7/2020, the Investigation report indicated Resident 1 had an unwitnessed fall while walking unassisted. According to the report, factors observed at the time of the fall was Resident 1 lost his balance. The report indicated under type of assistance Resident 1 was receiving at the time of fall, Resident 1 was alone and unassisted while walking. During a review of Resident 1's GACH Discharge Summary, dated 10/8/2020, the Discharge Summary indicated Resident 1 was seen in the GACH with a history of multiple falls with a recent ground level fall at the facility and was diagnosed with a frontal scalp contusion (a region of injured tissue or skin in which blood capillaries [fine branching blood vessels] have been ruptured; a bruise) and a nasal bone fracture. Resident 1 was admitted and closely monitored in the intensive care unit ([ICU] higher level of care) with repeated computerized tomography ([CT scan] combines a series of x-ray images taken from different angles around the body) of the head and face. Resident 1 was discharged from the GACH on 10/9/2020 back to the facility. During interviews on 11/30/2020 at 4:33 p.m. and 12/3/2020 at 4:24 p.m., Certified Nurse Assistant (CNA 1) stated Resident 1 spent most times in his room. CNA 1 stated she did not assist Resident 1 to get out of bed or when ambulating in his room. During an interview on 12/3/2020 at 4:44 p.m , Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 was very confused. LVN 1 stated it was not safe for Resident 1 to get up and walk by himself. LVN 1 stated Resident 1 needed to be reoriented and redirected back to bed multiple times during the shift because Resident 1 would attempt to get out of bed without assistance. During an interview on 3/4/2021 at 4:50 p.m., the Director of Nursing (DON) stated Resident 1 had several factors that made him a high risk for falls including impaired memory, exit seeking and psychotropic (relating to drugs that affect a person's mental state). During a review of the facility's undated policy and procedure (P/P) titled, Fall Management Program, the P/P indicated the facility must implement interventions to reduce the risk of falls.