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	11/30/2021

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident was free from physical abuse (Resident 2). Resident 1, who has a history of aggressive physical assaultive behavior with intent (resolved or determined to do [something]) was not supervised in the patio and pushed and kicked Resident 1 in the back. The facility failed to implement the physician's order for 27 days to separate Resident 2 in another building (the facility has multiple buildings) after Resident 2 was physically abused by Resident 1, to prevent further escalation (an increase in the intensity or seriousness of something) and injuries, which placed Resident 2 at ongoing risk for abuse. Resident 1 and Resident 2 continued to share the same bathroom and other common spaces. This failure resulted in Resident 2 being afraid and feeling mental anguish (a high degree of mental pain and distress; anxiety, embarrassment, or anger of such a severity that it causes a substantial disruption in the injured person's daily routine), and pain to the back and legs with decreased mobility requiring a wheelchair for mobility. On 11/9/2021 at 5:13 p.m., the Administrator (ADM) and the Director of Nursing (DON) were notified of the Immediate Jeopardy ([IJ], a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) situation that was called for the facility's failure to ensure Resident 2 was free from abuse F600. On 11/10/2021 at 4:12 p.m., the ADM and DON submitted an acceptable Plan of Action (POA) for the correction of the IJ, which included: 1. Resident 2 was referred to physical therapy for evaluation and appropriateness of wheelchair use on 11/9/2021. 2. Education was provided to licensed nurses by the DON/Designee on 11/10/2021 regarding Change of Condition (COC) including documentation of COC and notification of physicians. 3. Resident 1 was transferred to the hospital on 10/13/2021 for a psychiatric evaluation. (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
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. An order was obtained on 11/9/2021 [sic] from the psychiatrist to transfer Resident 2 to another building if possible. Resident 1 and Resident 2 were moved to separate halls in the Palm Grove building on 11/14/2021. Resident 2's transfer to another building attempted on 11/10/2021, however resident is currently refusing to move. 5. Resident 2 was referred to a psychologist for potential psychological impact on 11/10/2021. 6. Resident 1 and Resident 2 were referred to a psychiatrist for evaluation on 11/9/2021. The facility obtained orders for medication adjustments and labs from the psychiatrist on 11/9/2021. 7. Education provided by DON/Designee to department managers and licensed staff on 11/10/2021 regarding resident-to-resident altercation management: separate residents, physicians/psychiatrists are notified, and aggressor is referred for psychiatric evaluation. Aggressor is placed on 1:1 monitoring for safety. Physicians' orders are obtained and followed. Victim is monitored for potential emotional distress related to incident. 8. The Interdisciplinary Team ([IDT] the members of the treatment team to coordinate care and to document the communication among all members of the team) discusses resident to resident altercations daily in stand up including interventions and recommendations to prevent future altercations. Findings reported monthly to quality assurance ([QA] measures compliance against certain necessary standards) for three months. 9. Social services assistant (SSA) provided Resident 1 with education regarding conflict resolution and ways to cope with feelings and frustrations, encouraged resident to participate in activities to redirect their attention for positive and enjoyable outcomes 11/10/2021. 10. Residents 1 and 2's care plans were updated on 11/10/2021. 11. Social Services Staff to continue to provide emotional support as needed and encourage resident to ask for assistance to resolve any concerns related to their safety. On 11/10/2021 at 10:54 a.m., the ADM provided an acceptable plan of action (POA). During an observation, interview, and record review, while onsite, the ADM and the DON were notified the IJ was lifted, after the team verified the POA was followed and implemented. Findings: a. During a review of Resident 1's Admission Record (Face Sheet), the Face sheet indicated Resident 1 was admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 1's diagnoses included schizophrenia (a long-term mental disorder of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings), anxiety disorder (mental disorder causing difficultly in controlling anxiety and staying focused on daily tasks), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest) and severe psychotic features (mental disorder causes detachment from reality such as delusions, hallucinations, and disorganized thinking and speech). (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS), a comprehensive assessment and screening tool, dated 2/26/2021, the MDS indicated Resident 1 had moderate cognitive impairment (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 1 required supervision (oversight, encouragement, and cueing) with bed mobility, transfer, walk in room/corridor, eating and toileting. Resident 1 required limited assistance (staff provide guided maneuvering of limbs and other non-weight bearing assistance) for locomotion off unit (how resident moves to and returns from off-unit locations (areas such as dining, activities). During a review of Resident 1's untitled care plan, revised on 1/3/2021, the care plan indicated the resident had identified needs and behaviors which may lead to increased conflict with other peers/residents/staff and possible neglect and behaviors of pushing peers. The staff's interventions included but not limited to identifying increasing or escalating behaviors that require reevaluation and to identify specific behaviors that places resident at risk for aggression (hostile or violent behavior or attitudes toward another; readiness to attack or confront). During a review of the facility's undated document titled, Incidents by Incident Type, the document indicated Resident 1 had a physical aggressive incident on 1/7/2021 at 4:05 p.m. striking another resident. During a review of Resident 1's Behavior Note, dated 1/19/2021 and timed at 8:20 p.m., the note indicated Resident 1 was becoming difficult to redirect when she was following behind her peers being intrusive (causing disruption or annoyance through being unwelcome or uninvited) fighting with the air and throwing things within reach. The resident will not stay in her room to avoid issues. During a review of Resident 1's Behavior Note, dated 1/20/2021 and timed at 3:11 p.m., the note indicated Resident 1's behavior was intrusive toward peers and staff. The resident was seen kissing the pillar on the patio and continuing to be difficult to redirect, while arguing with peers. The Mental Health Worker (MHW) had to stop the resident (Resident 1) from striking peers daily. During a review of Resident 1's history and physical (H/P), dated 3/13/2021, the H/P indicated the resident has a history of Seasonal affective disorder ([SAD] a form of depression, seasonal depression, or winter depression) a problem with dementia (mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), depression, and a history of suicide attempt by trying to jump off a building. During a review of Resident 1's clinical psychologist (a professional who practices psychology and studies normal and abnormal mental states, perceptual, cognitive, emotional), dated 10/10/2021 and timed at 11 a. m. titled, Group therapy Progress Note, the note indicated Resident 1 displays elevated, irritable affect (severe form of unpredictable agitation), and anxious mood. The psychologist indicated Resident 1 meets the criteria of anxiety disorder (mental disorder with intense, excessive, and persistent worry and fear about everyday situations), decreased concentration, irritability, hypervigilance (state of heightened alertness accompanied by behavior that aims to prevent danger), fatigue, and worry. According to the psychologist note, Resident 1 has a history of aggressive speech and behaviors. During a review of Resident 1's Health Status Note, dated 10/13/2021 and timed at 11:20 a.m., the Health Status Note indicated Resident 1 had a physical aggression toward another resident (Resident 2). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's recapped physician orders, dated 10/15/2021, the order indicated a medication order placed on 3/7/2021 for Invega (medication is used to treat certain mental/mood disorder) 156 milligrams ([mg] unit of measurement) intramuscular injection (medication injected in the muscle) one time a day every 30 days related to schizoaffective disorder (mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania). During a review of Resident 1's Medication Administration Records (MAR) from 1/2021 through 10/2021, the MARs indicated Resident 1 had many behavioral episodes and required redirecting, documented as follow: 1. In 1/2021, Resident 1 exhibited 58 episodes of grandiose delusions (false or unusual belief about one's greatness) of having usual powers, 61 episodes of paranoid delusions (irrational feeling that someone is intending to harm), 65 episodes of behaviors responding to internal stimuli (carrying on a conversation alone or behaving or interacting as if someone or something else is present), 27 episodes of slamming of doors, and 51 episodes of continuous pacing (walking nonstop). 2. In 2/2021, Resident 1 exhibited 13 episodes of responding to internal stimuli (odd, bizarre behavior such as smiling, laughing, or talking to oneself or being preoccupied). 3. In 3/2021, Resident 1 exhibited 80 episodes of continuous pacing. 4. In 4/2021, Resident 1 exhibited 16 episodes of responding to internal stimuli, 22 episodes of throwing personal items on peers, staff and on the floor. 5. In 5/2021, Resident 1 exhibited 114 episodes of responding to internal stimuli and 86 episodes of continuous pacing. 6. In 6/2021, Resident 1 exhibited 41 episodes of responding to internal stimuli and 81 episodes of continuous pacing. 7. In 7/2021, Resident 1 exhibited 93 episodes of responding to internal stimuli and 96 episodes of continuous pacing. 8. In 8/2021, Resident 1 exhibited 51 episodes of responding to internal stimuli and 91 episodes of continuous pacing. 9. In 9/2021, Resident 1 exhibited 89 episodes of responding to internal stimuli and 111 episodes of continuous pacing. 10. In 10/2021, Resident 1 exhibited 89 episodes of responding to internal stimuli and 88 episodes of continuous pacing. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. During a review of Resident 2's Admission Record (Face Sheet), the face sheet indicated Resident 2 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 2's diagnoses included schizophrenia, anxiety disorder (mental disorder causing difficultly in controlling anxiety and staying focused on daily tasks) and bipolar disorder (mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 required assistance with activities of daily living ([ADL] self-care such as feeding, bathing, dressing, and grooming oneself), supervision (oversight, encouragement and or cueing) with bed mobility, transfer, walk in room/corridor, locomotion on unit and off unit, dressing, eating, and toileting use. During an interview, on 10/13/2021 at 12:11 p.m., Licensed Vocational Nurse 10 (LVN 10) stated the facility has been short-staffed on the unit. LVN 10 stated there were only five (5) staff members (CNAs and LVNs) on the shift. LVN 10 stated 6-7 staff were needed to provide for the residents in Palm Grove Unit (a psychiatric locked unit), which houses 74 residents. LVN 10 stated usually there are only five staff members to provide care and monitoring to the residents. During an interview with Certified Nursing Assistant 1 (CNA 1) on 10/13/2021 at 2:10 p.m., CNA 1 stated, We are short-staffed today. During a review of the facility's investigation of an unusual occurrence documented by the SSA 1 indicated the following: 1. Interview with the resident (Resident 2) on 10/13/2021 at 11:45 a.m., the resident (Resident 2) stated she was on the patio when that crazy lady (Resident 1) kicked me for no reason. 2. Interview with Mental Health Counselor (MHC 2) on 10/13/2021 at 2 p.m., MHC 2 stated he heard a thump and saw the resident (Resident 2) was on the ground (on 10/13/2021). MHC 2 stated resident (Resident 2) stated Resident 1 hit her. 3. Interview with resident (Resident 2) on 10/14/2021 at 3 p.m., Resident 2 stated she would like to move rooms due to her sharing a bathroom with Resident 1. The resident (Resident 2) complained of pain and requested a wheelchair. 4. Outcome of the investigation, not dated, stated the resident (Resident 1) have unpredictable behaviors of aggressive, paranoid (suspicious, fearful) thoughts and assaultive secondary to diagnosis of schizophrenia. The investigation concluded both residents were on the patio when the resident (Resident 1) kicked the other resident (Resident 2) unprovoked (occurring without any identifiable cause or justification) on the right side of her back which resulted in Resident 2 falling to the ground. During an interview, on 10/14/2021 at 9 a.m., Resident 2 stated she was on the outside patio after nutrition hour (morning snack) and was walking to throw away her trash, when she was struck on the back by Resident 1 and fell to the ground. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During on an interview on 10/15/2021 at 10 a.m., the DON stated the Social Services Assistant 1 (SSA1) reported the incident. The DON stated many residents have common aggressive behaviors that are not apparent until there is a trigger. The DON stated it was important for staff to learn the triggers. During an interview with SSA 1 on 10/15/2021 at 10:15 a.m., SSA 1 stated she reported the incident that occurred between Residents 1 and Resident 2 and was conducting the facility's investigation. During a review of Resident 2's Licensed Progress Note (LPN), dated 10/15/2021 and timed at 10:16 a.m., the LPN indicated Resident 2 complained of pain to the legs, spinal column (backbone) and rib cage (the bony frame formed by the ribs around the chest). Resident 2 stated she could not stand up. During a review of Resident 2's Change of Condition Evaluation (COC), dated 10/15/2021 and timed at 3:19 p.m., indicated the following: 1. Change of condition: complaint of pain 3/10 ([pain scale] 0 being no pain and 10 being the worse pain) to right leg, bilaterally ribs, and spine. 2. Resident (Resident 2) was given Tylenol (medication taken for mild pain relief) 500 mg in the a.m. and Ibuprofen (medication taken for mild pain relief) 400 mg in the afternoon. 3. Functional Status Evaluation: decreased mobility, recent onset and not resolving spontaneously. The resident (Resident 2) stated she is having trouble walking and is unable to stand up. During a review of Resident 2's clinical Psychologist Note (PN), dated 10/18/2021 and timed at 12:23 p.m., the PN indicated Resident 2 stated she was using a wheelchair due to her leg and back hurting after she was struck by another resident (Resident 1) and fell . Resident 2 stated she remains depressed and anxious about the incident. PN indicate that resident continued to display decreased social-interpersonal functioning, including social withdrawal, and decreased appropriate behaviors as well as delusions and paranoia. During a concurrent observation and interview, while on the facility's patio (Building A) on 10/19/2021 at 9:18 a.m., Resident 2 stated she does not feel safe in the facility and was concerned about her mobility. Resident 2 complained of pain to the right hip and rib cage. Resident 2 was sitting in a wheelchair and was using the wheelchair to move about the unit to patio. Resident 2 stated she was unable to walk due to pain and her body being severed after the fall. Resident 2 stated she started using the wheelchair after being pushed by the resident (Resident 1) and falling. During a telephone interview on 11/4/2021 at 1:33 p.m., Registered Nurse Supervisor 1 (RNS1), stated residents need close monitoring, especially while on the patio. RNS 1 stated residents must be monitored closely during smoking time and nutrition time, there should be at least two assigned staff, which can be a CNA and or Mental Health Counselor (MHC). During an interview on 10/21/2021 at 1:08 p.m., LVN 4 stated prior to the incident on 10/13/2021 of Resident 2 being pushed and kicked by Resident 1, Resident 2 was ambulatory (walked without assistance), but now she relies on the wheelchair to move around the unit and in her room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 11/4/2021 at 4:46 p.m., Resident 1's Psychologist 1 (P 1) stated Resident 1 continues to experience hallucinations and experiences mania (mental illness marked by periods of great excitement or euphoria, delusions, and overactivity). During a telephone interview with LVN 2 on 11/8/2021 at 1:25 p.m., LVN 2 stated as of that day (11/8/2021) Resident 2 was not walking and using wheelchair for locomotion. LVN 2 stated prior to the incident on 10/13/2021, Resident 2 walked independently. During a telephone interview with the DON on 11/8/2021 at 2:10 p.m., the DON stated she was not aware that Resident 1 had a history of pushing other residents, prior to 10/13/2021. The DON stated the staff must anticipate resident behaviors to identify triggers that could cause residents to act aggressively. The DON stated resident behaviors can be unpredictable and the staff must be able to visually see all residents in the patio, residents must be in their line of sight. During a telephone interview with Residents 1 and 2's psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) on 11/8/2021 at 3:32 p.m., the psychiatrist stated Resident 1 has a history of being intermittently agitated which she receives injections once month to control the behaviors. The psychiatrist stated he was called by the nursing staff on 10/13/2021 after the incident regarding Resident 2 being kicked by Resident 1 on the patio. The psychiatrist stated he gave a verbal order to the nurse to separate the residents (Resident 2) in different buildings where they will not share a common area. During a concurrent observation and interview with Resident 2 on 11/9/2021 at 2:30 p.m., in Building A's patio, Resident 2 was in a wheelchair and stated she feels like she will fall without the use of the wheelchair. Resident 2 stated she does not feel safe because she was pushed by a woman. Resident 2 stated, My back, hip and pelvis are broken, and my spine is severed by healing. Resident 2 stated she feels like she can be harmed again and wants to go home to her family. There was no staff observed supervising the residents. During an interview with LVN 1 on 11/10/2021 at 1:35 p.m., LVN 1 stated Residents 1 and 2 remain in the same building (Building A) and Resident 2 have not been moved to another building as per the physician's order. LVN 1 stated the residents have access to the same patio area and can be in the patio at the same time. During a review of the facility's policy and procedure (P/P), revised in 3/2018 and titled, Abuse Prohibition and Prevention Policy and Procedure and Reporting Reasonable Suspicion of a Crime in the Facility Policy and Procedure the P/P indicated residents must not be subjected to abuse by anyone, including but not limited to, facility, staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals.

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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** 44958 Based on interview and record review, the facility failed to ensure a resident physician's orders was implemented for one of one sampled resident (Resident 2). Resident 2 was physically abused by another resident (Resident 1) and the physician order for Resident 2 to be moved to another building in the facility, which was not implemented until over 27 days later (crossed referenced to F600). This failure of not following the physician's order and separating Resident 1 and 2 resulted in Resident 2 being afraid and feeling mental anguish (a high degree of mental pain and distress; anxiety, embarrassment, or anger of such a severity that it causes a substantial disruption in the injured person's daily routine), as they continued to share the same bathroom and common areas in the building. Findings: a. During a review of Resident 1's Admission Record (Face Sheet), the Face sheet indicated Resident 1 was admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 1's diagnoses included schizophrenia (a long-term mental disorder of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings), anxiety disorder (mental disorder causing difficultly in controlling anxiety and staying focused on daily tasks), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest) and severe psychotic features (mental disorder causes detachment from reality such as delusions, hallucinations, and disorganized thinking and speech). During a review of Resident 1's Minimum Data Set (MDS), a comprehensive assessment and screening tool, dated 2/26/2021, the MDS indicated Resident 1 had moderate cognitive impairment (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 1 required supervision (oversight, encouragement, and cueing) with bed mobility, transfer, walk in room/corridor, eating and toileting. Resident 1 requires limited assistance (staff provide guided maneuvering of limbs and other non-weight bearing assistance) for locomotion off unit (how resident moves to and returns from off-unit locations (areas such as dining, activities). During a review of Resident 1's untitled care plan, revised on 1/3/2021, the care plan indicated the resident had identified needs and behaviors which may lead to increased conflict with other peers/residents/staff and possible neglect and behaviors of pushing peers. The staff's interventions included but not limited to identifying increasing or escalating behaviors that require reevaluation and to identify specific behaviors that places resident at risk for aggression (hostile or violent behavior or attitudes toward another; readiness to attack or confront). During a review of Resident 1's history and physical (H/P), dated 3/13/2021, the H/P indicated the resident has a history of Seasonal affective disorder ([SAD] a form of depression, seasonal depression, or winter depression) a problem with dementia (mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), depression, and a history of suicide attempt by trying to jump off a building. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's clinical psychologist (a professional who practices psychology and studies normal and abnormal mental states, perceptual, cognitive, emotional), dated 10/10/2021 and timed at 11 a. m. titled, Group therapy Progress Note, the note indicated Resident 1 displays elevated, irritable affect (severe form of unpredictable agitation), and anxious mood. The psychologist indicated Resident 1 meets the criteria of anxiety disorder (mental disorder with intense, excessive, and persistent worry and fear about everyday situations), decreased concentration, irritability, hypervigilance (state of heightened alertness accompanied by behavior that aims to prevent danger), fatigue, and worry. According to the psychologist note, Resident 1 has a history of aggressive speech and behaviors. During a review of Resident 1's Health Status Note, dated 10/13/2021 and timed at 11:20 a.m., the Health Status Note indicated Resident 1 had a physical aggression toward another resident (Resident 2). b. During a review of Resident 2's Admission Record (Face Sheet), the face sheet indicated Resident 2 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 2's diagnoses included schizophrenia, anxiety disorder (mental disorder causing difficultly in controlling anxiety and staying focused on daily tasks) and bipolar disorder (mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 required assistance with activities of daily living ([ADL] self-care such as feeding, bathing, dressing, and grooming oneself), supervision (oversight, encouragement and or cueing) with bed mobility, transfer, walk in room/corridor, locomotion on unit and off unit, dressing, eating, and toileting use. During a review of the facility's investigation of an unusual occurrence documented by the SSA 1 indicated the following: 1. Interview with the resident (Resident 2) on 10/13/2021 at 11:45 a.m., the resident (Resident 2) stated she was on the patio when that crazy lady (Resident 1) kicked me for no reason. 2. Interview with Mental Health Counselor (MHC 2) on 10/13/2021 at 2 p.m., MHC 2 stated he heard a thump and saw the resident (Resident 2) was on the ground (on 10/13/2021). MHC 2 stated resident (Resident 2) stated Resident 1 hit her. 3. Interview with resident (Resident 2) on 10/14/2021 at 3 p.m., Resident 2 stated she would like to move rooms due to her sharing a bathroom with Resident 1. The resident (Resident 2) complained of pain and requested a wheelchair. 4. Outcome of the investigation, not dated, stated the resident (Resident 1) have unpredictable behaviors of aggressive, paranoid (suspicious, fearful) thoughts and assaultive secondary to diagnosis of schizophrenia. The investigation concluded both residents were on the patio when the resident (Resident 1) kicked the other resident (Resident 2) unprovoked (occurring without any identifiable cause or justification) on the right side of her back which resulted in Resident 2 falling to the ground. (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	11/30/2021

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 10/14/2021 at 9 a.m., Resident 2 stated she was on the outside patio after nutrition hour (morning snack) and was walking to throw away her trash, when she was struck on the back by Resident 1 and fell to the ground. During an interview with SSA 1 on 10/15/2021 at 10:15 a.m., SSA 1 stated she reported the incident that occurred between Residents 1 and Resident 2 and was conducting the facility's investigation. During a review of Resident 2's Licensed Progress Note (LPN), dated 10/15/2021 and timed at 10:16 a.m., the LPN indicated Resident 2 complained of pain to the legs, spinal column (backbone) and rib cage (the bony frame formed by the ribs around the chest). Resident 2 stated she could not stand up. During a review of Resident 2's Change of Condition Evaluation (COC), dated 10/15/2021 and timed at 3:19 p.m., indicated the following: 1. Change of condition: complaint of pain 3/10 ([pain scale] 0 being no pain and 10 being the worse pain) to right leg, bilaterally ribs, and spine. 2. Resident (Resident 2) was given Tylenol (medication taken for mild pain relief) 500 mg in the a.m. and Ibuprofen (medication taken for mild pain relief) 400 mg in the afternoon. 3. Functional Status Evaluation: decreased mobility, recent onset and not resolving spontaneously. The resident (Resident 2) stated she is having trouble walking and is unable to stand up. During a review of Resident 2's clinical Psychologist Note (PN), dated 10/18/2021 and timed at 12:23 p.m., the PN indicated Resident 2 stated she was using a wheelchair due to her leg and back hurting after she was struck by another resident (Resident 1) and fell . Resident 2 stated she remains depressed and anxious about the incident. PN indicated that resident continued to display decreased social-interpersonal functioning, including social withdrawal, and decreased appropriate behaviors as well as delusions and paranoia. During a concurrent observation and interview, while on the facility's patio (Building A) on 10/19/2021 at 9:18 a.m., Resident 2 stated she does not feel safe in the facility and was concerned about her mobility. Resident 2 complained of pain to the right hip and rib cage. Resident 2 was sitting in a wheelchair and was using the wheelchair to move about the unit to patio. Resident 2 stated she was unable to walk due to pain and her body being severed after the fall. Resident 2 stated she started using the wheelchair after being pushed by the resident (Resident 1) and falling. During an interview on 10/21/2021 at 1:08 p.m., LVN 4 stated prior to the incident on 10/13/2021 of Resident 2 being pushed and kicked by Resident 1, Resident 2 was ambulatory (walked without assistance), but now she relies on the wheelchair to move around the unit and in her room. During a telephone interview with LVN 2 on 11/8/2021 at 1:25 p.m., LVN 2 stated as of that day (11/8/2021) Resident 2 was not walking and using wheelchair for locomotion. LVN 2 stated prior to the incident on 10/13/2021, Resident 2 walked independently. (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	11/30/2021

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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview with Residents 1 and 2's psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) on 11/8/2021 at 3:32 p.m., the psychiatrist stated Resident 1 has a history of being intermittently agitated which she receives injections once month to control the behaviors. The psychiatrist stated he was called by the nursing staff on 10/13/2021 after the incident regarding Resident 2 being kicked by Resident 1 on the patio. The psychiatrist stated he gave a verbal order to the nurse to separate the residents (Resident 2) in different buildings where they will not share a common area. During an interview with LVN 1 on 11/10/2021 at 1:35 p.m., LVN 1 stated Residents 1 and 2 remain in the same building (Building A) and Resident 2 have not been moved to another building as per the physician's order. LVN 1 stated the residents have access to the same patio area and can be in the patio at the same time. During a review of the facility's policy and procedure (P/P), titled Physician Orders, Accepting, Transcribing and Implementing (Noting), revised 11/2012, indicated Licensed nursing personnel will ensure that telephone and verbal orders will be recorded and implemented.