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	03/21/2023

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11912 Based on interview and record review, the facility failed to ensure the resident was free of physical abuse for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure Certified Nurse Assistant 1 (CNA 1) did not physically assault Resident 1, by hitting him in the eye. 2. Ensure the facility's staff adhere to its policy and procedure (P/P) titled, Abuse Prohibition/Prevention Policy and Procedure, which indicated each resident has the right to be free from abuse and mistreatment. These failures resulted in Resident 1's rights being denied, and the resident being hit by CNA 1 in the left eye and sustained discoloration to the left eye. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was initially admitted to the facility on [DATE] and last readmitted on [DATE] with diagnoses including paranoid (obsessively suspicious) schizophrenia (a mental disorder characterized by abnormal social behavior and failure to understand what is real) and post-traumatic stress disorder ([PTSD] a mental health condition triggered by a terrifying event - either experiencing it or witnessing it). During a review of Resident 1's history and physical (H/P), dated 2/25/2021, the H/P indicated Resident 1 was diagnosed as having PTSD, schizophrenia, and was confused. During a review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 1/3/2021, the MDS indicated Resident 1 usually had the ability to understand and be understood and had moderately impaired cognitive (thought process) skills for daily decision-making. According to the MDS, Resident 1 had no behavioral problems. (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 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Order Summary Report (active attending physician's orders) dated 3/31/2021, the report indicated there was a physician order dated 12/6/2020, for Haldol Decanoate (an antipsychotic used for long-term treatment of mental disorders) solution 50 milligrams ([mg] unit of measurement) per milliliter ([ml] unit of measurement) injection to be given 1.5 ml once every 28 days, related to the resident's paranoid schizophrenia behavior manifestation by aggression-hitting behavior. During a review of Resident 1's Medication Administration Record (MAR) for the month of 3/2021, the licensed nurse (unidentified) documented Resident 1 received Haldol Decanoate Solution 50 mg injection on 3/9/2021 at 9 a.m. During a review of Resident 1's Nursing Progress Note (NPN) dated 3/28/2021 and timed at 6 a.m., the NPN indicated Resident 1 complained a male CNA (CNA 1) hit him in the face two days prior (3/26/2021). According to the NPN, an assessment Resident 1 was noted to have a fading black discoloration underneath the left eye which measured 3.5 X 2.0 centimeters ([cm] unit of measurement) and the resident denied pain. On 3/28/2021, at 6:40 a.m., an unidentified licensed nurse documented Resident 1 stated CNA 1 hit him in the face because the resident was cursing at CNA 1. The NPN indicated the abuse incident was reported to the local police department, California Department of Health (CDPH) and Ombudsman (resident advocate). The NPN indicated CNA 1 was interviewed about the abuse and he stated, That Friday morning around 10 a. m., I went into Resident 1's room and was caring for the resident's roommate, Resident 2. A janitor came in the room and Resident 1 started cursing (using expletive/obscenity/profanity words) at the janitor. I (CNA 1) told him to stop, and he (Resident 1) would not stop and then the resident started to curse at me. CNA 1 stated he held Resident 1's chin and closed the Resident 1's mouth, trying to get him shut up. CNA 1 stated he may have held the resident down too hard and caused the bruising. The NPN indicated CNA 1 was suspended immediately and sent home. During a review of the CNA 1's documentation report for the month of 3/2021, CNA 1 was Resident 1's primary CNA on the following days 3/1/2021, 3/3/2021, 3/4/2021, 3/7-10/2021, 3/13/2021, 3/14/2021, 3/16/2021, 3/19/2021, 3/21/2021, and 3/25-27/2021. During a review of Resident 1's NPN dated 3/28/2021 and timed a 9:15 p.m., the NPN indicated the police came to the facility to speak to Resident 1 about the abuse incident.When the police officer (PO 1) saw Resident 1's eye, PO 1 called 911 (emergency services) for the resident to be evaluated. According to the NPN, the paramedics arrived, evaluated Resident 1, and stated the resident needed no further care from them. During a review of Resident 1's Change in Condition Evaluation (COC), dated 3/28/2021, the COC indicated there was a fading discoloration on Resident's 1 left eye measuring 3.0 X 2.0 c.m. with skin intact and no swelling. The COC indicated the resident's skin was intact and the resident was not complaining of pain at that time. The COC indicated Resident 1 stated CNA 1 hit him in the face because he (Resident 1) cursed at CNA 1 and he had a black eye after CNA 1 hit him. The COC summary indicated CNA 1 was suspended immediately pending investigation. During a review of CNA 1's Notice of Employee Separation (NES) dated 4/1/2021, the NES indicated the hire date was 1/30/2019 and the termination date was 4/1/2021. The NES, under Involuntary Termination, indicated CNA 1 was terminated for violating company policies. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview with Resident 1 on 5/13/2021 at 1:38 p.m., Resident 1 stated, The case was closed, and a police officer (PO 1) came to the facility and interviewed me a month ago about the CNA hitting me. I do not want to continue to drag this out after being hit by the CNA, I just want to get out of here. During an interview with Registered Nurse 1 (RN) 1 on 1/18/2023 at 4:10 p.m., RN 1 stated CNA 1 admitted to holding Resident 1's mouth close because the resident was cursing at him. RN 1 stated she sent CNA 1 home immediately (3/26/2021) and reported the incident to the director of nurses (DON). During an interview with Licensed Vocational Nurse 1 (LVN 1) on 2/6/2023 at 1:30 p.m., LVN 1 stated she recalled the incident between Resident 1 and CNA 1. LVN 1 stated she could not recall the CNA's name and CNA 1 no longer worked at the facility. During an interview with the social service designee (SSD) on 2/7/2023 at 11 a.m., the SSD stated she remembered the incident, however, she was not able to recall CNA 1's name. There was no investigation report available for review. During an interview with the director of staff development (DSD) on 2/14/2023 at 10 a.m., CNA 1's employment file was requested and the DSD stated she would call back once located. On 2/15/2023 at 10:40 a.m., the DSD stated CNA 1 employment file could not be located in the facility. CNA 1 was not available for interview due to the lack of contact information and employee file from the DSD. During a review of the facility's policy and procedure (P/P), with a revised date of 3/2018 and titled, Abuse Prohibition/Prevention Policy and Procedure, the P/P indicated each resident has the right to be free from abuse, neglect, exploitation, misappropriation of property, and mistreatment.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11912 Based on interview and record review, the facility failed to ensure an abuse allegation between a CNA (CNA 1) and Resident 1 was thoroughly investigated after Resident 1 alleged he was struck by in the face/eye by CNA 1. The facility failed to: 1. Ensure the abuse allegation was thoroughly investigated when Resident 1 alleged CNA 1 hit him in the face. 2. Ensure the facility's staff adhere to its policy and procedure (P/P) titled, Abuse Prohibition/Prevention Policy and Procedure, which indicated an investigation would be condcuted promptly and documented in a report. This deficient practice of not investigating the alleged abuse of CNA 1 against Resident 1 had the potential for further abuse to occur in the facility. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was initially admitted to the facility on [DATE] and last readmitted on [DATE] with diagnoses including paranoid (obsessively suspicious) schizophrenia (a mental disorder characterized by abnormal social behavior and failure to understand what is real) and post-traumatic stress disorder ([PTSD] a mental health condition triggered by a terrifying event - either experiencing it or witnessing it). During a review of Resident 1's history and physical (H/P), dated 2/25/2021, the H/P indicated Resident 1 was diagnosed as having PTSD, schizophrenia, and was confused. During a review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 1/3/2021, the MDS indicated Resident 1 usually had the ability to understand and be understood and had moderately impaired cognitive (thought process) skills for daily decision-making. According to the MDS, Resident 1 had no behavioral problems. During a review of Resident 1's Order Summary Report (active attending physician's orders) dated 3/31/2021, the report indicated there was a physician order dated 12/6/2020, for Haldol Decanoate (an antipsychotic used for long-term treatment of mental disorders) solution 50 milligrams ([mg] unit of measurement) per milliliter ([ml] unit of measurement) injection to be given 1.5 ml once every 28 days, related to the resident's paranoid schizophrenia behavior manifestation by aggression-hitting behavior. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Nursing Progress Note (NPN) dated 3/28/2021 and timed at 6 a.m., the NPN indicated Resident 1 complained a male CNA (CNA 1) hit him in the face two days prior (3/26/2021). According to the NPN, upon an assessment Resident 1 was noted to have a fading black discoloration underneath the left eye which measured 3.5 X 2.0 centimeters ([cm] unit of measurement) and the resident denied pain. On 3/28/2021, at 6:40 a.m., a licensed nurse documented Resident 1 stated CNA 1 hit him in the face because the resident was cursing at CNA 1. The NPN indicated the abuse incident was reported to the local police department, CDPH and Ombudsman (resident advocate). The NPN indicated CNA 1 was interviewed about the abuse and he stated, That Friday morning around 10 a.m., I went into Resident 1's room and was caring for the resident's roommate, Resident 2. A janitor came in the room and Resident 1 started cursing (using expletive/obscenity/profanity words) at the janitor. I (CNA1) told him to stop, and he (Resident 1) would not stop and then the resident started to curse at me. CNA 1 stated he held Resident 1's chin and closed the Resident 1's mouth, trying to get him shut up. CNA 1 stated he may have held the resident down too hard and caused the bruising. The NPN indicated CNA 1 was suspended immediately and sent home. During a review of Resident 1's NPN dated 3/28/2021 and timed a 9:15 p.m., the NPN indicated the police came to the facility to speak to Resident 1 about the abuse incident and when the police officer (PO1) saw Resident 1's eye and he called 911 (emergency services) for the resident to be evaluated. According to the NPN, the paramedics arrived, evaluated Resident 1, and stated the resident needed no further care from them. During a review of Resident 1's Change in Condition Evaluation (COC), dated 3/28/2021, the COC indicated there was a fading discoloration on Resident's 1 left eye measuring 3.0 X 2.0 c.m. with skin intact and no swelling. The COC indicated the resident's skin was intact and the resident was not complaining of pain at that time. The COC indicated Resident 1 stated CNA 1 hit him in the face because he (Resident 1) cursed at CNA 1 and he had a black eye after CNA 1 hit him. The COC summary indicated CNA 1 was suspended immediately pending investigation. During an interview with Resident 1 on 5/13/2021 at 1:38 p.m., Resident 1 stated, The case was closed, and a police officer (PO 1) came to the facility and interviewed me a month ago about the CNA hitting me. I do not want to continue to drag this out after being hit by the CNA, I just want to get out of here. During an interview with Registered Nurse 1 (RN) 1 on 1/18/2023 at 4:10 p.m., RN 1 stated CNA 1 admitted to holding Resident 1's mouth close because the resident was cursing at him. RN 1 stated she sent CNA 1 home immediately (3/26/2021) and reported the incident to the director of nurses (DON). During an interview with the social service designee (SSD) on 2/7/2023 at 11 a.m., the SSD stated she remembered the incident, however, she was not able to recall CNA 1's name. The SSD stated there was no investigation report available for review and one should have been done. During an interview with the director of staff development (DSD) on 2/14/2023 at 10 a.m., CNA 1's employment file was requested. On 2/15/2023 at 10:40 a.m., the DSD stated CNA 1 employment file could not be located in the facility. CNA 1 was not available for interview due to the lack of contact information from the DSD and no available employee file. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P/P), with a revised date of 3/2018 and titled, Abuse Prohibition/Prevention Policy and Procedure, the P/P indicated all incidents of suspected or alleged abuse would be promptly investigated by the assigned staff and prepares an investigation report documenting the findings of the investigation.