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	03/14/2023

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** 44958 Based on interview and record review, the facility failed to ensure a resident, who had a wandering (a person that roams around and becomes lost or confused about their location) behavior and had a history of aggressive behavior (hitting and yelling at others) did not physically abuse another resident for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure Certified Nursing Assistant 1 (CNA 1) had knowledge of Resident 1's wandering behavior and monitor Resident 1's whereabouts on the day of the incident (3/2/2023). 2. Ensure to have an assigned CNA to monitor the hallway on the day of the incident (3/2/2023) to prevent Resident 1 from wandering into Resident 2's room and hitting Resident 2 in the forehead with a bottle of lotion. This deficient practice resulted in Resident 1 wandering into Resident 2 room, throwing a lotion bottle at Resident 2, hitting Resident 2 face, and causing the resident pain. Resident 2 sustained a bruise (an injury appearing as an area of discolored skin on the body, caused by a blow or impact rupturing underlying blood vessels) on her forehead. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and anxiety (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). During a review of Resident 1's history and physical (H/P), dated 12/18/2022, the H/P indicated Resident 1 did not have the ability to understand and make decisions. (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 12/23/2022, the MDS indicated that Resident 1 had unclear speech and sometimes was able to understand and be understood by others. According to the MDS, Resident 1 required extensive assistance (resident involved in activity, staff provide weight-bearing [body weight] support) with a one-person physical assist during toilet use (how resident uses toilet room, commode, bedpan, transfers on and off toilet) and transferring. The MDS indicated Resident 1 had hallucinations (perceptual experiences in the absence of real external stimuli) and delusions (misconceptions of beliefs that are firmly held, contrary to reality). According to the MDS Resident 1 used a wheelchair (w/c) as a mobility device. During a review of Resident 1's care plan (CP), untitled, initiated on 8/5/2015 and revised on 7/7/2022, the CP indicated Resident 1 was wandering into other residents rooms and was at risk for injury to self or others secondary to impaired mental health condition. The CP indicated the goal for Resident 1 was not to have injuries to self and not to cause injuries to others weekly. The CP interventions included staff to monitor Resident 1's whereabouts and remove Resident 1 from any source of agitation and redirect the resident. During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including Type 2 diabetes mellitus (diseases that result in too much sugar in the blood) and muscle weakness and anxiety disorder. During a review of Resident 2's History and Physical (H/P), dated 2/3/2023, the H/P indicated Resident 2 did not have the ability to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had moderately impaired cognitive skill (the core skills your brain uses to think, read, learn, remember, reason, and pay attention) for daily decision-making and required extensive assistance with one-person physical assistance for toilet use and transferring. During a review of Resident 2's Change of Condition (COC) form, dated 3/2/2023, the COC indicated Resident 2 was hit on the left forehead by Resident 1 with a bottle. During a review of Resident 2's Interdisciplinary (IDT) Progress Notes (PN), dated 3/3/2023, the IDT PN indicated that an incident of physical aggression between Resident 1 and Resident 2 occurred on 3/2/2023 at 9:30 am. The IDT PN indicated the Registered Nurse received a report from a Charge Nurse indicating Resident 1 threw a bottle at Resident 2 hitting Resident 2 on the left side of the forehead. Resident 2 was assessed and noted to have mild bluish discoloration appropriately 3.0 by 2.0 centimeters [(cm)-unit of measurement of length] to the left side of her forehead. The IDT PN indicated Resident 2 was oriented to name, place, and time. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/14/2023 at 11:00 a.m., with CNA 1, CNA 1 stated on 3/2/2023 at 9:30 a.m., he was assigned to Resident 1, however, he was not aware of Resident 1's whereabouts. CNA 1 stated he was in another resident's room at the time of the incident. CNA 1 acknowledged there should be an assigned CNA responsible for monitoring the hallway to prevent accidents, fights and to redirect residents from wandering into other residents' rooms. CNA 1 stated he did not know who was assigned to be the hallway monitor during the time of the incident. CNA 1 stated the CNA assigned to monitor the hallway observes the residents with wandering behavior to ensure they do not wander into other residents' rooms. The CNA assigned to monitor the hallway must always keep an eye on the hallway traffic. During an interview on 3/14/2023 at 11:10 a.m., with Registered Nurse Supervisor (RNS 1), RNS 1 stated Resident 1 had a history of wandering into other residents' rooms. RNS 1 stated the facility assigned CNA to monitor the hallway in hourly intervals to ensure residents do not fall in the hallways, ensure residents do not wander into other residents' rooms and to prevent any accidents or fights between residents. RNS 1 stated when a CNA is assigned to monitor hallway, the CAN's job is to be at the end of the hallway and monitor the residents that are in the hallway. RNS 1 stated the assigned CNA must always maintain line of sight on the residents in the hallway. RNS 1 stated if a CNA, who is assigned to monitor the hallway is called to help another resident, the CNA must have another staff member take over monitoring the hallway. During an interview on 3/17/2023 at 4 p.m. with the Director of Nursing (DON), the DON stated the facility must provide appropriate supervision to meet the needs of the residents. The DON stated Resident 1 had a known history of wandering into other residents' rooms and being aggressive. The DON stated, the facility had a system in place to ensure there was a hallway monitoring to supervise residents in the hallway. The DON stated the staff assignment which included the hallway assignment was not created for 3/2/2023 and more than likely there was no CNA directly assigned to watch the hallway which would have prevented Resident 1 from entering Resident 2's room. During a phone interview on 3/20/2023 at 4 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 3/2/2023 at approximately 9:35 a.m., she heard Resident 2 yelling for help in her room. LVN 1 stated as she entered Resident 2's room and met Resident 1 exiting from Resident 2's room in his wheelchair. LVN 1 stated Resident 2 informed her that Resident 1 hit her on the forehead with a bottle. LVN 1 stated she saw a bottle on the floor next to Resident 2's bed but did not witness the incident that Resident 2 described. LVN 1 stated Resident 1 should not have been in Resident 2's room. LVN 1 stated Resident 1 was known wanderer and should have been redirected from entering Resident 2's room. During a review of the facility's policy and procedure (P/P) titled, Safety and Supervision of Residents, revised 7/2017, the P/P indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility -wide policies. The P/P indicated the facility has an individualized, resident- centered approach to safety, the IDT team shall analyze information obtained from assessment and observations to identify any specific accident hazard or risks for individual residents, implement interventions to reduce accident risks and hazards shall include the following: communicating specific interventions to all relevant staff assigning responsibility for carrying out interventions, ensuring interventions are implemented and documenting interventions.