STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055036	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Healthcare Center	2625 Maple Ave. Los Angeles, CA 90011

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 - Minimal harm or potential for 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** 47883 Based on interview and record review, the facility failed to protect the resident ' s right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of four sampled residents (Resident 2). By failing to ensure CNA3 who was assigned to monitor Resident 2 did not leave the resident unsupervised on 4/20/2024. As a result, Resident 1 punched Resident 2 with a closed fist in the face on 4/20/2024 at 7:15 P.M., after Resident 1 wandered into Resident 2 ' s room. Findings: A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 10/27/2023 with diagnoses including chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and bipolar disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme high manic episodes to low depression episodes). A review of Resident 1 ' s Minimum Data Set (MDS - an assessment and care screening tool), dated 2/2/2024, indicated the resident had moderately impaired cognition (a moderate damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 1 did not exhibit any physical or verbal behavioral symptoms directed towards others. A review of Resident 1 ' s care plan (a plan of care that summarizes a resident ' s health conditions, specific care needs, and current treatments) initiated 11/12/2023, indicated Resident 1 had alteration in behaviors manifested by aggression. The care plan interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) indicated to attempt to remove or eliminate stimuli causing behavioral outbursts as possible. A review of Resident 1`s Situation-Background-Assessment and Recommendation Communication Form (SBAR- a written communication tool that helps provide important information), dated 4/20/2024, indicated that the resident was aggressive towards Resident 2 when Resident 2 entered Resident 1 ' s room. (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 - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2 ' s Admission Record indicated the facility admitted the resident on 12/27/2022 with diagnoses including diabetes type 2 (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly), dementia, and schizoaffective disorder (a condition of combination of two mental illnesses schizophrenia [a serious mental disorder in which people interpret reality abnormally] and mood disorder [a disorder described by marked disruptions in emotions]). A review of Resident 2 ' s History and Physical (HP), dated 2/28/2024, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 2 ' s MDS, dated [DATE], indicated the resident had difficulty focusing attention and had disorganized thinking as well as an altered level of consciousness (a change in a patient's state of awareness [ability to relate to self and the environment] and arousal [alertness]). The MDS indicated Resident 2 did not exhibit any physical or verbal behavioral symptoms directed towards others. A review of Order Summary Report, dated 4/1/2024, indicated physician order dated 03/21/2024 to provide every hour checks alternating between nurse and Certified Nursing Assistant (CNA). A review of Resident 2 ' s Care Plan, initiated 12/27/2022, indicated Resident 2 was at risk for wandering and/or elopement from the facility related to dementia. The Care Plan interventions updated on 03/20/2024 included visual checks every 15 minutes. The care plan indicated that no changes was made on 4/11/2024. A review of Resident 2 ' s medication administration record (MAR) from 4/1/2024 to 4/30/2024 indicated Resident 1 was to be monitored for the whereabouts every day at 1AM, 3AM, 5AM, 7AM, 9AM, 11AM, 1PM, 3PM, 5PM, 7PM, 9PM, and at11PM. A review of Resident 2`s SBAR Communication Form, dated 4/11/2024, indicated Resident 2 was in another resident ' s room and ran into the door when trying to leave.  A review of Resident 2`s SBAR Communication Form, dated 4/20/2024, indicated that the resident was struck by Resident 1 when he wandered into Resident 1 ' s room. During an observation in Resident 2 ' s room on 4/25/2024 at 10:45 AM, the resident was observed to be well-groomed and fully dressed in his bed. Resident 2 was not able to answer when asked whether he (Resident 2) was struck by Resident 1. Resident 2 appeared confused and was nonreceptive to questions. During an observation in Resident 1 ' s room on 4/25/2024 at 10:56 AM, the surveyor observed Resident 1 inside his room laying in his bed. Resident 1 was unable to speak. Resident 1 started shaking his head and arms and making incoherent noises when asked if he struck another resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/25/2024 at 1 PM, Certified Nursing Assistant 4 (CNA 4) stated, on 4/20/2024, during the 3PM-11PM shift, I was not assigned to Resident 1 or Resident 2. Two other CNAs [unnamed] were on their lunch break. I was in the hallway around 7:15 PM when I observed Resident 2 going very fast toward Resident 1 ' s room. I was trying to redirect Resident 2, but he was very fast and went inside Resident 1 ' s room where I witnessed Resident 1 punch Resident 2 in face and Resident 2 fell , sitting on the floor. CNA 4 stated, I interrupted the fight, called for help and when Certified Nursing Assistant 3 (CNA 3) came to help, together we removed Resident 2 from the room. During a telephone interview on 4/25/2024 at 12:52 PM, CNA 3 stated on 4/20/2024, during the 3PM-11PM shift, I was assigned to monitor elopement risk residents. I was at the nursing station doing the CNA ' s charting audit and heard that CNA 4 was screaming for help. I went over and observed Resident 2 sitting on the floor in Resident 1 ' s room, crawling back towards the door. CNA 4 was trying to pick Resident 2 up and I helped her. Resident 2 returned to his usual strolling in the hallway without any distress. We immediately notified Registered Nurse 1 (RN1) about the incident. During an interview on 4/25/2024 at 1:23PM, the Director of Nursing (DON) stated according to the job description, CNAs were responsible for resident monitoring were not supposed to do any other duties such as charting audits. The DON stated it was best practice not to send two CNAs on break at the same time to effectively monitor the residents with wandering and elopement behavior, as well as to prevent resident-to-resident abuse in the facility. During a concurrent interview and record review on 4/25/2024 at 3:15 PM, the Minimum Data Set Nurse (MDSN) reviewed Resident 2 ' s care plans and stated that no new interventions were implemented after the wandering episode of Resident 2 on 4/11/2024. The MDSN stated that care plan interventions were required to be updated after each episode of behavior to monitor for effectiveness. A review of the facility ' s policy and procedures (P&P) titled Wandering and Elopement, revised 3/21/ 2024, indicated: If identified as at risk for wandering, elopement, or other safety issues, the resident ' s care plan will include strategies and intervention to maintain the resident ' s safety. A review of the facility ' s P&P titled Abuse Prevention Program, revised December 2016, indicated: Our residents have the right to be free from abuse, neglect and misappropriation of resident property and exploitation. As part of the resident abuse prevention, the administration will protect our residents from abuse by anyone including but not necessarily limited to facility, staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individuals.