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	08/28/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49571 Based on interview and record review, the facility failed to report an allegation of abuse to the State Survey Agency, local law enforcement, and Ombudsman within two hours for one of five sampled residents (Resident 1). The deficient practice resulted in a delay of an on-site inspection by the State Survey Agency to ensure investigating Resident 1's allegation of abuse. Findings: A review of Resident 1's Face sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including lack of coordination, schizoaffective disorder - unspecified, and major depressive disorder without psychotic features. During an interview on 8/28/2024 at 11:30 AM, Resident 1 stated over a week ago, she was trying to return a coffee cup to the kitchen and got hit on her back by one of the residents (Resident 2). Resident 1 stated, early morning around 6 AM (unable to recall specific day) Resident 2 came behind her cursing at her, asking why she was getting a coffee, then Resident 2 hit Resident 1 on the back between her shoulders. Resident 1 stated a Certified Nursing Assistant (CNA 1) witnessed the incident and I remember it was two days before Sunday. Resident 1 stated, When Resident 2 hit me in the back, I had to turn away quickly and I felt pain and a spasm (muscle cramp) below my back neck area. During an interview on 8/28/2024 at 1:06 PM, the Director of Staff Development (DSD) stated abuse prevention and mandatory abuse reporting training was provided to LVN 1 during hire, as needed, and annually. The DSD stated abuse allegations had to be reported within two hours with injury or twenty-four hours if there was no injury. The DSD stated, I have interviewed the charge nurse (LVN 1) on the morning of the incident and LVN 1 failed to report the incident to facility leadership and appropriate agencies. During an interview on 8/28/2024 at 1:21 PM, CNA 1 stated on the morning of 8/16/2024 around 6 AM, she heard a commotion in front of the kitchen area and ran towards Resident 1 and Resident 2, who were arguing about a coffee. CNA 1 stated, I did not witness a physical contact, but I had to separate the aggressor (Resident 2) from the victim (Resident 1), who claimed she was hit by Resident 2. CNA 1 stated, I separated the residents and reported the incident to the night shift charge nurse (LVN 1). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility document indicated this incident between Resident 1 and Resident 2 was reported with the allegation of abuse to the California Department of Public Health (Department), on 8/19/2024 at 10:56 AM (three days after the incident). A review of Resident 1's Radiology Report dated 8/24/2024, indicated the reason for the study was pain in thoracic spine (upper middle back). The report indicated Resident 1's conclusion findings was a cervical spasm (involuntary contractions or tightening of the neck muscles). A review of Resident 1's Medication Administration Record (MAR) dated 8/24/2024, indicated to apply Lidocaine External Patch 5% (a medicated adhesive patch to relieve pain) to posterior cervical spine (the neck region of spinal backbone) in the morning for pain every 12 hours. During an interview on 8/28/2024 at 1:26 PM, the Director of Nursing (DON) stated LVN 1 previously received abuse prevention and abuse reporting training. LVN 1 has acknowledged that he was supposed to report the incident to the facility's abuse coordinator and appropriate agencies within the specific time frame, depending on the severity of the abuse. The DON stated LVN 1 was terminated from the facility for failure to report this abuse allegation timely. During an interview on 8/28/2024 at 2:25 PM, the facility abuse coordinator / Administrator (ADM) stated the facility leadership was not informed at the time of the incident and as soon as she was aware of the incident an investigation and report was made. The ADM stated any abuse allegations should be reported within two hours when there was an injury and twenty-four hours if there was no evidence of injury. The ADM acknowledged the facility failed to report an abuse allegation timely. A review of the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting, dated 4/11/2024, indicated all alleged violations of abuse, neglect would be reported immediately, but not later than two (2) hours if the alleged violation involved abuse or resulted in serious bodily injury.