Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

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	09/26/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44309 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 2), who was a known wanderer, received services to prevent accidents. Resident 2 was not supervised or monitored per the physician's order and the person centered care plan. This deficient practice caused an increased risk for accidents and injuries. Findings: A review of Resident 2 ' s Admission Record (Face Sheet) indicated the facility admitted the resident on 6/3/2024, with diagnoses including dementia (loss of cognitive functioning- thinking, remembering, and reasoning- to such an extent that the loss interferes with a person ' s daily life and activities), schizophrenia (a serious mental disorder in which people interpret reality abnormally), and anxiety disorder (a condition in which a person has excessive feelings of fear, and uneasiness). A review of the Admission / Re-Admission Data Tool Form dated 6/3/2024, indicated Resident 2 was transferred from another facility due to the need for close monitoring because of his confusion, and per his family request. A review of the Physician ' s Order dated 6/3/2024, indicated to provide visual checks for Resident 2 every hour, alternating between Licensed Nurses and Certified Nursing Assistants (CNA). A review of the Physician ' s History and Physical (H&P) dated 6/4/2024, indicated Resident 2 was not competent (capable) to understand his medical condition. A review of Resident 2 ' s Wandering Assessment Form dated 6/7/2024, indicated the resident did not understand his surroundings, was experiencing feelings of anger / fear of abandonment, had diagnoses of dementia with psychosis (when people lose some contact with reality), and was a known wanderer with history of wandering. A review of the At Risk for Wandering / Elopement Care Plan dated 6/7/2024, indicated Resident 2's goal was to minimize the risks of wandering out of facility daily for three months. The care plan interventions indicated to orient the resident to key areas in the facility such as dining room, bathroom, business office, and kitchen and to assist him to go to key areas as needed, to provide visual checks for the resident every hour alternating between licensed nurse and CNA, and to monitor resident's location through visual checks and redirect as needed. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/9/2024, indicated the resident's cognitive skills for daily decision making (ability to think, remember, express thoughts, and make decisions) was severely impaired (never/rarely made decisions). The MDS indicated Resident 2 did not exhibit wandering behavior (when a person with dementia roams around with no clear destination, becomes lost or confused about their location) which was a discrepancy compared to the care plan and the wandering assessment. During an interview on 9/26/2024 at 8:50 AM, Certified Nursing Assistant (CNA) 1 stated Resident 2 was confused and staff were monitoring Resident 2 frequently because he was a wanderer. CNA 1 was not able to state how often the staff were monitoring Resident 2 nor the location of the documented monitoring. During a concurrent interview and record review on 9/26/2024 at 12 PM, with the facility's Infection Preventionist Nurse (IP), Resident 2's care plans and MARs were reviewed. The IP stated licensed nurses were required to document their monitoring inside the resident's Medication Administration Record (MAR). The IP stated there were no documentations of visual checks or monitoring inside Resident 2's MAR for the months of July, August, or September 2024. During a concurrent interview and record review on 9/26/2024 at 12:11 PM, with the facility's Director of Nursing (DON), Resident 2's Physician's Orders and MARs were reviewed. The DON stated there were no hourly monitoring documented by licensed nurses for Resident 2 in the medical record for the months of July, August, and September 2024. The DON stated CNAs were completing the high risk for wandering visual check logs every 15 minutes for all residents who were at high risk for wandering and elopement. However, there were days that this visual monitoring log was not completed for Resident 2. The DON stated there was no one hour visual monitoring log available for CNAs to complete for Resident 2. The DON stated staff was required to implement the interventions of the person-centered care plans. The DON further stated the potential outcome of not monitoring residents who were at high risk for wandering was accidents and injuries. A review of the facility's policy and procedure titled, Routine Resident Checks, dated 4/11/2024, indicated the nursing supervisor / charge nurse shall keep documentation related to these routine resident checks, including the time, identity of the person making checks, and the outcome of each check. A review of the facility's policy and procedure titled, Safety and Supervision of Residents, dated 4/11/2024, indicated resident supervision was a core component of the systems approach to safety. The type and frequency of resident supervision was determined by the individual resident's assessed needs and identified hazards in the environment. The type and frequency of resident supervision may vary among residents and over time for the same resident.