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	10/09/2024

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50296 Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident 1), who had severe cognitive impairment, had legally documented representation for decision making on behalf of the resident. This deficient practice caused Resident 1's rights to be violated as a resident living in the facility. Findings: A review of Resident 1's admission record (facesheet) indicated the resident was admitted to the facility on [DATE], with diagnoses including epilepsy (a disorder in which nerve cell activity in the brain is disturbed), schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly), unspecified psychosis (a mental disorder characterized by a disconnection from reality), and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations). The admission record indicated Resident 1 was self responsible. A review of Resident 1's History and Physical dated 6/4/24 indicated, General consent for medical care and treatment was obtained verbally from the resident, next of kin, and / or decision maker: consent to all medical and surgical care, examinations and tests determined by physician to be necessary. A review of the Physician's Order Summary Report dated 8/9/24 indicated facility staff was to monitor Resident 1 for the use of Ativan (a controlled substance used to treat anxiety), Haldol (an antipsychotic medication treats mental disorders) and Ziprasidone (an anitpsychotic treats schizophrenia). The Physician's Order Summary Report indicated the consent for the medications was obtained by the physician and not the resident or responsible party. A review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 6/3/24 and 9/7/24 indicated the resident had severe cognitive impairment (problems with a person's ability to think, remember, use judgement, and make decisions). The MDS indicated Resident 1 had inattention, behavior indicators of psychosis, hallucinations, and verbal behavioral symptoms directed toward others. During interview on 10/8/24 at 2:05 p.m., the Activities Assistant (AA) stated Resident 1 was doing well in participation with activities, enjoyed coloring, but did have an outbursts in the past. (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During concurrent interview and record review on 10/9/24 at 8:12 a.m. with the Social Services Director (SSD), Resident 1's physical chart was reviewed. The SSD stated Resident 1 was self-responsible because the resident had no family members, but the resident had a case manager and the case manager was notified if there was an issue or change of condition. During observation on 10/9/24 at 10:19 a.m., in the activity room, Resident 1 was standing and screaming, then was escorted out of the activity room. During a concurrent interview and record review on 10/9/24 at 11:15 a.m. with the Minimum Data Set Nurse (MDSN), Resident 1's MDS was reviewed. The MDSN stated that upon admission on 6/3/24 and on 9/7/24, Resident 1's BIMS score (brief interview for mental status) was 7, which indicated severe cognitive impairment. During telephone interview on 10/10/24 at 2:30 p.m., the Director of Nursing (DON) stated she was unsure what the facility policy indicated regarding residents with cognitive issues who were deemed self-responsible but require representation. The DON stated their practice was to have legal documentation indicating an assigned representative for the resident. The DON did not provide legal documentation for Resident 1's representative. A review of the facility's policy and procedure titled, Resident Representative, dated 2/2021 indicated, Documentation designating that the representative has been delegated the necessary authority to exercise the resident's rights for decision-making issues is obtained by the director of nursing or a designee.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50296 Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident 1), who had severe cognitive impairment, or the resident representative was informed and participated in the resident's care and treatment. This deficient practice caused Resident 1's rights to be violated as a resident living in the facility. Findings: A review of Resident 1's admission record (facesheet) indicated the resident was admitted to the facility on [DATE], with diagnoses including epilepsy (a disorder in which nerve cell activity in the brain is disturbed), schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly), unspecified psychosis (a mental disorder characterized by a disconnection from reality), and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations). The admission record indicated Resident 1 was self responsible. A review of Resident 1's History and Physical dated 6/4/24 indicated, General consent for medical care and treatment was obtained verbally from the resident, next of kin, and / or decision maker: consent to all medical and surgical care, examinations and tests determined by physician to be necessary. A review of the Physician's Order Summary Report dated 8/9/24 indicated facility staff was to monitor Resident 1 for the use of Ativan (a controlled substance used to treat anxiety), Haldol (an antipsychotic medication treats mental disorders) and Ziprasidone (an anitpsychotic treats schizophrenia). The Physician's Order Summary Report indicated the consent for the medications was obtained by the physician and not the resident or responsible party. A review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 6/3/24 and 9/7/24 indicated the resident had severe cognitive impairment (problems with a person's ability to think, remember, use judgement, and make decisions). The MDS indicated Resident 1 had inattention, behavior indicators of psychosis, hallucinations, and verbal behavioral symptoms directed toward others. During interview on 10/8/24 at 2:05 p.m., the Activities Assistant (AA) stated Resident 1 was doing well in participation with activities, enjoyed coloring, but did have an outbursts in the past. During concurrent interview and record review on 10/9/24 at 8:12 a.m. with the Social Services Director (SSD), Resident 1's physical chart was reviewed. The SSD stated Resident 1 was self-responsible because the resident had no family members, but the resident had a case manager and the case manager was notified if there was an issue or change of condition. During observation on 10/9/24 at 10:19 a.m., in the activity room, Resident 1 was standing and screaming, then was escorted out of the activity room. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/9/24 at 11:15 a.m. with the Minimum Data Set Nurse (MDSN), Resident 1's MDS was reviewed. The MDSN stated that upon admission on 6/3/24 and on 9/7/24, Resident 1's BIMS score (brief interview for mental status) was 7, which indicated severe cognitive impairment. During telephone interview on 10/10/24 at 2:30 p.m., the Director of Nursing (DON) stated she was unsure what the facility policy indicated regarding residents with cognitive issues who were deemed self-responsible but require representation. The DON stated their practice was to have legal documentation indicating an assigned representative for the resident. The DON did not provide legal documentation for Resident 1's representative. A review of the facility's policy and procedure titled, Resident Representative, dated 2/2021 indicated, Documentation designating that the representative has been delegated the necessary authority to exercise the resident's rights for decision-making issues is obtained by the director of nursing or a designee.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50296 Based on interview and record review, the facility failed to ensure Staff 1 (the housekeeper) had proper documentation of a background check in the employee file as part of abuse prevention. This failure had the potential to result in an employee working at the facility with potential violations of abuse. Findings: A review of Resident 3's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including fracture of the left tibia (the inner and typically larger of the two bones between the knee and the ankle), lack of coordination, essential hypertension (high blood pressure). A review of Resident 3's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/27/24 indicated the resident had no acute change in mental status, had symptoms of feeling down with little interest or pleasure in doing things. A review of Resident 3's care plan for Alteration in Psychosocial Wellbeing related to alleged physical altercation with staff (Staff 1, housekeeper) dated 9/26/24, indicated to identify issues causing stress to the resident and address issues of concerns. During concurrent interview and record review on 10/9/24 at 11:57 a.m. with the Director of Staff Development (DSD), Staff 1's employee file indicated there was no background check included in the file. The DSD stated Staff 1 was hired in January 2023. This indicated for over one year, Staff 1 worked at the facility in housekeeping, but had no background check completed. During further review of Staff 1's employee file, there was no evidence of abuse training upon hire. The DSD stated all employees should receive Abuse Training upon hire, quarterly, and as needed (when an incident occurred). During interview on 10/9/24 at 1:55 p.m., the DSD stated a background check was completed 'today' on 10/9/24 for Staff 1. During interview on 10/9/24 at 2:08 p.m., the Administrator, who was the Abuse Coordinator, confirmed Staff 1 did not have a background check included in the employee file. A review of facility's policy and procedure titled, Abuse Prevention Program, dated 4/11/24, indicated as part of the resident abuse prevention program, the Administrator would conduct employee background checks.