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	01/15/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36395 Based on interview and record review the facility failed to implement measures to prevent loss of personal belongings for one of three sampled residents (Resident 1). For Resident 1, the facility failed to: 1.Ensure Resident 1's belongings list was reviewed and itemized to ensure all the personal belongings were given to Resident 1 when Resident 1 was discharged from the facility on 12/6/24. 2.Ensure the replacement hearing aids received by Resident 1 on 1/7/25 was an appropriate and correct fit for Resident 1. These deficient practices resulted in Resident 1 not given his right to keep his belongings secure while at the facility and to receive all the belongings when Resident 1 was discharged from the facility on 12/6/24. Findings: During a review of Admission Record of Resident 1, the Admission Record indicated the facility admitted Resident 1 on 2/9/24 with diagnoses including dementia (progressive state of decline in mental abilities), difficulty walking and abnormalities of gait and mobility. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 11/15/24, the MDS indicated Resident 1 had minimal difficulty in hearing. The MDS also indicated Resident 1 had moderately impaired cognitive skills. Resident 1 had behavior of inattention (difficulty focusing attention such as being easily distracted or having difficulty keeping track of what is being said) that was continuously present. Resident 1 needed supervision with upper body dressing, putting on/taking off footwear, personal hygiene, set up with oral hygiene, toileting hygiene, lower body dressing and independent with eating. 1.During a review of Resident 1's Resident's Clothing and Possessions (On Admission) dated 2/19/24, the document indicated Resident 1 had belongings that included two hearing aids, one pair of slippers, two chargers, one razor machine, five t-shirts, four sweatpants. However, Resident 1's Resident's Clothing and Possessions were not filled out to indicate what belongings Resident 1 received when Resident 1 was discharged from the facility on 12/6/24. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's next of kin (NOK) electronic mail (email) dated 1/5/25 at 3:03 p.m., sent to the social service designee (SSD), the email indicated Resident 1 was missing hearing aids, phone charger, shaver, slippers, one t-shirt and a pair of sweats. During a concurrent interview and record review on 1/6/25 at 10:50 a.m., the email sent by Resident 1's NOK dated 1/5/25 was reviewed with the administrator (ADM). The ADM stated Resident 1's NOK informed him that Resident 1 did not get all his belongings. Resident 1's NOK stated that the staff did not went over the inventory list when Resident 1 was discharged on [DATE]. The ADM stated the facility should have gone over the inventory list with Resident 1's NOK but was not done. During a concurrent interview and record review on 1/15/25 at 10:42 a.m. Resident 1's Resident's Clothing and Possessions was reviewed with the director of nursing (DON). The DON stated when Resident 1 was discharged on [DATE] the staff should have reviewed the belongings list with Resident 1's NOK to ensure all belongings were given to Resident 1. 2.During an interview on 1/15/25 at 9:26 a.m., the social service designee (SSD) stated Resident 1 lost his hearing aids on 5/7/24. The SSD stated the hearing aids were replaced and Resident 1 received the hearing aids on 9/25/24, but Resident 1 lost the same hearing aids the following day 9/26/24. The SSD stated Resident 1 was discharged to another facility on 12/6/24 to Facility B without the replacement hearing aids. The SSD stated the replacement hearing aids were mailed to Resident 1 and was received by Resident 1 on 1/7/25. The SSD further added the hearing aid center was not able to do the replacement hearing aid fitting (includes ensuring the hearing aids are fitted correctly, have the right settings and how to use the hearing aids) for Resident 1 because the hearing aid center does not service Facility B area, where Resident 1 currently resides. During a telephone interview on 1/17/25 at 3:47 p.m., Resident 1's NOK stated the replacement hearing aid was received on 1/7/25 but Resident 1 was unable to use the replacement hearing aid. The NOK stated the hearing aid center who replaced Resident 1's hearing aid does not go to Facility B to do the hearing aid fitting The NOK further added .there's no one available to show how to use the hearing aids, how to turn it on, there was no direction on how to use the hearing aid and there was no charger. Resident 1's NOK stated Resident 1 had no hearing aid since 5/24. During a review of the facility Policy titled Discharging the Resident reviewed on 4/11/24, the Policy indicated when discharging the resident to home or another long-term facility, review the personal effects inventory with the resident or responsible party and have them sign off that they have received all personal effects and have them sign off that they have received all personal effects. During a review of the facility Policy titled Lost and Found reviewed on 4/11/24, the Policy indicated our facility shall assist all personnel and residents in safeguarding their personal property.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 36395 Based on interview and record review the facility failed to develop and implement care plan for one of three sampled residents (Resident 1). For Resident 1 who had severe hearing loss on the left and right ears, the facility failed to: 1. Ensure Resident 1's care plan included appropriate interventions for Resident 1 who had severe hearing loss and needed hearing aids to hear clearly. 2. Address and provide appropriate interventions when Resident 1 constantly misplaced his hearing aids. Resident 1 lost his hearing aids on 5/7/24 and lost the replacement hearing aids on 9/26/24. These deficient practices had the potential for Resident 1 to have sensory deprivation and affect Resident 1's mental, physical, and psychosocial well-being. Findings: During a review of the Admission Record of Resident 1, the Admission Record indicated the facility admitted Resident 1 on 2/9/24 with diagnoses including dementia (progressive state of decline in mental abilities), difficulty walking and abnormalities of gait and mobility. During a review of Resident 1's Care Plan initiated on 3/18/24, the Care Plan indicated Resident 1 was hard of hearing and used hearing aid to hear clearly. The care plan goal included Resident 1 will show gradual positive progress towards interacting with others at least once a week for three months. However, care plan interventions did not address Resident 1's condition of hard of hearing, the use of the hearing aids and Resident 1's identified behavior of constantly losing the hearing aids. During a review of the Social Service Note dated 5/14/24 at 1:18 p.m., the Note indicated on 5/7/24 at 3:45 p. m., Resident 1 reported that he lost his hearing aids. The SSD Notes indicated SSD and other staff looked for Resident 1's hearing aids in Resident 1's room, trash cans and laundry area but was unable to find the missing hearing aids. The SSD notes also indicated Resident 1's hearing aid center was notified, and the hearing aid will be replaced. During a review of the Pure Tone Audiogram (routine clinical examination used to identify hearing loss) dated 5/14/24, the document indicated Resident 1 had severe hearing loss on the left and right ears. During a review of the Licensed Nurses Notes dated 9/26/24 at 3:39 p.m., the Nurses Notes indicated Resident 1 (who received the replacement hearing aids on 9/25/24) lost the replacement hearing aids on 9/26/24. Resident 1 stated he did not know what happened to the hearing aids. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 11/15/24, the MDS indicated Resident 1 had minimal difficulty in hearing. The MDS indicated Resident 1 had moderately impaired cognitive skills. Resident 1 had behavior of inattention (difficulty focusing attention such as being easily distracted or having difficulty keeping track of what is being said) that was continuously present. Resident 1 needed supervision with upper body dressing, putting on/taking off footwear, personal hygiene, set up with oral hygiene, toileting hygiene, lower body dressing and independent with eating. During an interview on 1/6/25 at 9:55 a.m., licensed vocational nurse (LVN 1) stated Resident 1 was .very forgetful and requires a lot of redirections and reminders so it would not have been a good idea to keep his hearing aids at bedside. LVN 1 further stated Resident 1 was very hard of hearing and .you would have to speak to him very close to his ear. During a concurrent interview and record review on 1/6/25 at 12:32 p.m., Resident 1's Care Plan dated 3/18/24 was reviewed with the director of nursing (DON). The DON stated Resident 1 was able to read your lips, understand written words and had to be spoken to loudly. The DON stated she was unable to find care plan interventions for Resident 1's condition of hard of hearing. During an interview on 1/15/25 at 9:26 a.m., the social service designee (SSD) stated Resident 1 . easily loses the hearing aid, he loses it frequently. Once reported, we search the room, and we will find the hearing aid under the bed or on the side of his bed. The SSD stated on 5/7/24 the staff reported that Resident 1 lost the hearing aids, and the facility was unable to find the lost hearing aids. The SSD stated it took four months to replace Resident 1's hearing aids. On 9/25/24, the SSD stated, Resident 1 received the replacement hearing aids but lost the hearing aids the next day on 9/26/24. During an interview on 1/15/25 at 10:03 a.m., LVN 2 stated there was a care plan created for Resident 1 regarding Resident 1's condition of hard of hearing and use of hearing aids, but the interventions were incomplete. LVN 2 stated interventions would include risk for miscommunication, risk for fall. LVN 2 further added that there are a lot of interventions that could be implemented for Resident 1. During an interview on 1/15/25 at 10:39 a.m., certified nursing assistant (CNA 1) stated Resident 1 constantly loses his hearing aids. CNA 1 stated we look for the hearing aid and most of the time we find it in the cabinet, under the bed or under his pillows. During a review of the facility Policy titled Care Plans, Comprehensive Person-Centered reviewed on 4/11/24, the Policy indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The same Policy indicated the comprehensive, person-centered care plan will include: 1.describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 2.incorporate identified problem areas. 3.incorporate risk factors associated with identified problems. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4.build on the resident's strengths. 5.aid in preventing or reducing decline in the resident's functional status and /or functional levels. The same policy also indicated the assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change.