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	01/28/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36395 Based on interview and record review the facility failed to ensure the medication administration was in accordance with the professional standard of practice for one of three sampled residents (Resident 1). For Resident 1, the facility failed to record the administration site when Resident 1 was given the Lantus (drug used to control the amount of sugar in the blood) 20 units subcutaneously (SQ, under the skin) during the month of 12/24. This deficient practice had the potential for Resident 1 to have the Lantus given SQ in the same injection site that could lead to skin damage. Findings: During a review of the Admission Record indicated the facility originally admitted Resident 1 on 7/21/23 and readmitted on [DATE] with diagnoses including diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), long term use of insulin (hormone that removes excess sugar from the blood, can be produced by the body or given artificially by medication) and lack of coordination. During a review of the Minimum Data Set (MDS, resident assessment tool) dated 12/31/24 indicated Resident 1 had moderately impaired cognitive skills. Resident 1 needed moderate assistance (helper does less than half of the effort) with toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear and supervision with eating, oral hygiene and upper body dressing. During a review of Resident 1's Medication Administration Record (MAR, daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 12/24 indicated a physician order for Lantus inject 20 units give SQ at bedtime for diabetes. The MAR indicated to record the site of the injection. The injection site was recorded as not applicable (NA) on 12/1/24, 12/2/24, 12/5/24, 12/6/24, 12/11/24, 12/12/24, 12/13/24, 12/14/24, 12/16/24, 12/17/24, 12/18/24, 12/19/24 and 12/20/24. During a telephone interview on 1/28/25 at 11:06 a.m., licensed vocational nurse (LVN 1) stated NA means not applicable. LVN 1 stated she documented by mistake. LVN 1 stated she administered the Lantus SQ to Resident 1. LVN 1 stated she would usually give the Lantus to Resident 1on alternate sites such as on the left arm, right arm and in the abdomen and should be documented. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review Resident 1's MAR for 12/24 was reviewed with the director of nursing (DON) on 1/28/25 at 11:41 a.m. The DON stated the NA entry in the MAR was not correct. The DON stated injection site for the Lantus administration should be documented in Resident 1's MAR. During a review of the facility's policy and procedures (P&P) titled Documentation of Medication Administration, reviewed on 1/16/25, the P&P indicated the facility shall maintain a medication administration record to document all medications administered. Documentation must include as a minimum that included method of administration (e.g. oral, injection (and site). During a review of the facility's P&P titled Administering Medications reviewed on 1/16/25, the P&P indicated medications are administered in accordance with prescriber orders, including any timeframe. The same Policy indicated as required or indicated for a medication, the individual administering the medication records in the resident's medical record included the route of administration and the injection site (if applicable).

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36395 Based on interview and record review the facility failed to reconcile (a process of reviewing complete medication regimen during admission, transfer or discharge) a physician order upon re-admission to the facility for one for three sampled residents (Resident 1). For Resident 1, the facility failed to continue the physician's order for Lantus (drug used to control the amount of sugar in the blood) 20 units subcutaneously (SQ, under the skin) once a day at bedtime when Resident 1 was readmitted to the facility on [DATE]. This deficient practice resulted in Resident 1 not given the Lantus 20 units SQ for six days and had the potential for Resident 1 to suffer from hyperglycemia (high blood sugar). Findings: During a review of the Admission Record indicated the facility originally admitted Resident 1 on 7/21/23 and readmitted on [DATE] with diagnoses including diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), long term use of insulin (hormone that removes excess sugar from the blood, can be produced by the body or given artificially by medication) and lack of coordination. During a review of the Minimum Data Set (MDS, resident assessment tool) dated 12/31/24 indicated Resident 1 had moderately impaired cognitive skills. Resident 1 needed moderate assistance (helper does less than half of the effort) with toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear and supervision with eating, oral hygiene and upper body dressing. During a review of the general acute hospital (GACH 1) Patient's Home Medications on discharge date d 12/26/24 indicated to continue taking the following medications that included Lantus 20 units SQ once a day at bedtime. During a review of Resident 1's Medication Administration Record (MAR, daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 12/24 indicated the Lantus 20 units SQ, had an x from 12/26/25 to 1/1/25. During a review of the Physician Order dated 1/1/25 at 11:52 p.m., indicated an order to give Resident 1 Lantus inject 20 units SQ at bedtime. During a telephone interview on 1/28/25 at 11:06 a.m., licensed vocational nurse (LVN 1) stated Resident 1 should be given Lantus and if not given Resident 1's .blood sugar will skyrocket. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/28/25 at 11:41 a.m., Resident 1's MAR for 12/24 and Resident 1's GACH 1 Patient's Home Medications on discharge date d 12/26/24 were reviewed with the director of nursing (DON). The DON stated the Lantus 20 units was not included in the admission physician orders when Resident 1 was readmitted to the facility on [DATE]. DON stated the Lantus should have been included in the admission order on 12/26/24. As a result, Resident 1 missed the doses of Lantus 20 units for six days. DON stated Resident 1 needed the Lantus because without the Lantus Resident 1 had the potential for alteration in glucose level and potential hyperglycemia. DON stated LVN 1 called the physician on 1/1/25 and received an order to give Resident 1 Lantus 20 units at bedtime. During a review of the facility's policy and procedures (P&P) titled Admission Assessment and Follow Up: Role of the Nurse reviewed on 1/16/25, the P&P indicated reconcile the list of medications from the medication history, admitting orders, the previous MAR (if available) and the discharge summary from the previous institution, according to established procedures. The same Policy indicated to contact the attending physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings.