

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Maple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>36395</p> <p>Based on interview and record review the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding risks, benefits and alternatives offered) for one of three sampled residents (Resident 1). For Resident 1, the facility failed to obtain informed consent from Resident 1 and Resident 1 ' s responsible party (RP) before administering the Haldol (medication used to treat certain mental/mood disorders) on 1/26/25.</p> <p>This deficient practice resulted in Resident 1 and Resident 1 ' s RP not given their right to know the risks and benefits of taking the Haldol and alternative treatment available.</p> <p>Findings:</p> <p>During a review of the Admission Record indicated the facility admitted Resident 1 on 1/3/25 with diagnoses including schizoaffective disorder (chronic mental illness that causes a person to experience dramatic changes in their thoughts, moods, and behaviors) and hypothyroidism (when the thyroid gland [small, butterfly-shaped gland in front of neck] creates less than the normal amount of thyroid hormone).</p> <p>During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 1/8/25 indicated Resident 1 was cognitively intact. Resident 1 needed set-up (helper sets up, resident completes activity) with eating, oral hygiene, toileting hygiene, shower/bathe self, personal hygiene and independent with upper /lower body dressing and putting/taking off footwear.</p> <p>During a review of Resident 1's Behavior Note dated 1/26/25 at 2:25 p.m., indicated Resident 1 was exhibiting physical and verbal aggression towards staff. Resident 1 ' s psychiatrist was notified and gave one time order that included Haldol five milligrams (mg. - metric unit of measurement, used for medication dosage and/or amount) to be administered intramuscularly (IM, the injection of medication into a muscle).</p> <p>During a review of Resident 1 ' s Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 1/26/25 indicated the Haldol was given to Resident 1 on 1/26/25 at 2:11 p.m.</p> <p>(continued on next page)</p>

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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s care plan initiated on 1/26/25 indicated Resident 1 had an episode of verbal and physical aggression towards staff. The care plan goal indicated Resident 1 will verbalize understanding of need to control physically aggressive behavior through the review date. The care plan intervention included to give Resident 1 as many choices as possible about care and activities.</p> <p>During a concurrent interview and record review on 2/14/25 at 11:27 a.m., Resident 1 ' s MAR and progress notes dated 1/26/25 were reviewed with the director of staff development (DSD). DSD stated Resident 1 had verbal and aggressive behavior towards staff on 1/26/25. Resident 1 ' s psychiatrist was notified and gave order that included to give Resident 1 Haldol five mg. IM as one time order. DSD stated the Informed Consent should be obtained and filled out even though the Haldol was a one-time order.</p> <p>During an interview on 2/14/25 at 12:35 p.m., LVN 1 stated informed consent should be obtained from Resident 1 ' s RP before administering the Haldol.</p> <p>During review of the email sent on 2/14/25 at 2:36 p.m., the medical record director (MRD) confirmed that Resident 1 had no informed consent for the Haldol.</p> <p>During a review of the facility's policy and procedures (P&P) titled Informed Consent reviewed on 1/16/25, the P&P indicated, it is the policy of the facility to involve residents in their care decisions by facilitating information and obtaining consent for the use of psychotropic drugs, physical restraints and medical devices that may lead to the inability of a patient to regain use of a normal bodily functions after prolonged use. The same Policy indicated in an emergency in which it is impractical to obtain the consent order for psychotropic drugs, may be initiated upon a physician order without informed consent for a period of 48 hours. Informed consent must then be obtained to continue the medication, physical restraint or medical device.</p> <p>Based on interview and record review the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding risks, benefits and alternatives offered) for one of three sampled residents (Resident 1). For Resident 1, the facility failed to obtain informed consent from Resident 1 and Resident 1's responsible party (RP) before administering the Haldol (medication used to treat certain mental/mood disorders) on 1/26/25.</p> <p>This deficient practice resulted in Resident 1 and Resident 1's RP not given their right to know the risks and benefits of taking the Haldol and alternative treatment available.</p> <p>Findings:</p> <p>During a review of the Admission Record indicated the facility admitted Resident 1 on 1/3/25 with diagnoses including schizoaffective disorder (chronic mental illness that causes a person to experience dramatic changes in their thoughts, moods, and behaviors) and hypothyroidism (when the thyroid gland [small, butterfly-shaped gland in front of neck] creates less than the normal amount of thyroid hormone).</p> <p>(continued on next page)</p>		

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