

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 06/23/2025
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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) who had a diagnosis of dementia (a progressive state of decline in mental abilities) was free from physical abuse (any intentional act causing injury or trauma to another person through bodily contact) and verbal abuse (abuse that involves the use of oral or written language directed to a victim, can include the act of harassing, labeling, insulting, scolding, rebuking, or excessive yelling towards an individual) by failing to:</p> <p>Ensure the facility's Security Guard (Sec 1) did not curse (using words in a negative or aggressive way to express anger, disrespect, or to cause distress) at Resident 1 and did not hit Resident 1 on the back of the head with an open hand on 6/19/2025 at approximately 9:40 PM.</p> <p>On 6/19/2025 at approximately 9:40 PM, Certified Nursing Assistant 1 (CNA1) witnessed Sec1 arguing with Resident 1 and saw Sec 1 hit Resident 1 on the back of Resident 1's head with an open palm. On 6/20/2025 at 3:14 PM Resident 1 went to the General Acute Care Hospital (GACH) for further evaluation.</p> <p>This failure resulted in Resident 1 being physically abused by Sec1, experienced pain in his head, expressed being embarrassed, and required a transfer to the GACH.</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record dated 6/23/2025, the admission Record indicated Resident 1 was admitted on [DATE] with the diagnoses of encephalopathy (a disease or damage that affects the brain, leading to a change in how it functions), muscle weakness, Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia, lack of coordination, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), low back pain, other abnormalities of gait and mobility (a person's way of walking or moving is different from what's considered normal), cerebral infarction (what happens when part of your brain does not get enough blood and oxygen, leading to tissue damage or death).</p> <p>During a review of Resident 1's History and Physical (H&P) dated 1/9/2025, the H&P indicated Resident 1 was not competent (having the necessary ability, knowledge, or skill to do something successfully) to understand his medical condition.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Care Plan Report dated 1/9/2025, the Care Plan Report indicated if Resident 1 would become hostile or angry during care, the staff (in general) needed to stop giving care and attempt again at a later time. The Care Plan Report indicated for the staff (in general) to ask for assistance if Resident 1 would get resistive.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/14/2025, the MDS indicated Resident 1 had the ability to understand others and make himself understood. The MDS indicated Resident 1 used a wheelchair.</p> <p>During a review of Resident 1's Situation Background and Recommendation form (SBAR, tool used by healthcare workers when there is a change of condition among the residents) dated 6/19/2025 at 9:45 PM, the SBAR indicated Resident 1 had approached the nursing station yelling out loud because a staff (unidentified) had redirected Resident 1 not to enter the women's hall. The SBAR indicated Resident 1 became irritable and a CNA (unidentified on the SBAR) was called to help escort Resident 1 to his room. The SBAR indicated Sec 1 yelled out to stop to Resident 1 and Resident 1 was heard yelling and cursing. The SBAR indicated the staff (unidentified on the SBAR) asked Resident 1 to please go to your room. The SBAR indicated the CNA (unidentified on the SBAR) reported Sec 1 hit Resident 1 on the top of the head with an open hand.</p> <p>During a review of Resident 1's Progress Notes dated 6/19/2025 at 9:56 PM, the Progress Note indicated at approximately 9:40 PM Sec1 allegedly (something is claimed to have happened, but there is no concrete proof, or it has not been proven) assaulted Resident 1. The Progress Notes indicated the facility notified Resident 1's Medical Doctor (MD) and the local police department. The Progress Notes indicated Sec1 was not allowed to return to the facility.</p> <p>During a review of Resident 1's Police Investigation Report dated 6/19/2025, the Police Investigation Report indicated the date and time of the occurrence was 6/19/2025 at 10 PM. The Investigation Report indicated PD 1 and PD 2 were sent to Resident 1's facility on 6/20/2025 at approximately 12:15 AM. The Investigation Report indicated Resident 1 stated he (Resident 1) was assaulted by a staff member at the resident's facility. The Investigation Report indicated Resident 1 was not happy with his care level. The Investigation Report indicated Resident 1 believed the janitor or security slapped him with his left hand to the back of his head. The Investigation Report indicated the suspect cursed at Resident 1. The Investigation Report indicated Resident 1 advised the officers he (Resident 1) had a lump on the back of his head cause by the suspect, but the lump was not visible to the officers. The Investigation Report indicated the suspect was Sec 1 and indicated Sec 1 fled prior to police arrival. The Investigation Report indicated the police searched for the suspect but did not find him.</p> <p>During a review of Resident 1's Progress Notes dated 6/20/2025 at 7:38 AM, the Progress Notes indicated Resident 1 was being monitored for victim altercation, and able to accurately recall some details of the situation to the police officers.</p> <p>During a review of Resident 1's Phone Order dated 6/20/2025, at 10:26 AM, indicated to transfer Resident 1 to the GACH for evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Interdisciplinary Team (IDT, a group of healthcare professionals from different disciplines caring for the resident) Review General note dated 6/20/2025 at 11:20 AM, the IDT Review General note indicated the guy (Sec 1) slapped him on his head. The IDT Review General note indicated Resident 1 stated his head hurt (no pain level indicated on the IDT General note) and requested something for pain. The IDT Review-General note indicated the IDT recommendation was to send Resident 1 to the Emergency Department (ER) for an evaluation and treatment as needed.</p> <p>During a review of Resident 1's GACH Patient Information indicated Resident 1's admit date was 6/20/2025 at 3:14 PM for Aggressive Behavior.</p> <p>During a review of Resident 1's Progress Notes dated 6/21/2025, at 12:16 AM, The Progress Notes indicated Resident 1 returned back to the facility at 11:56 PM (6/20/2025). The Progress Notes indicated the GACH no longer accepted aggressive residents.</p> <p>During a concurrent observation in Resident 1's room and interview on 6/23/2025 at 10:21 AM, Resident 1 appeared to be groggy (feeling tired, weak, and not fully awake or clear-headed) and talked in a low voice. Resident 1 stated he did not know why Sec 1 hit him. Resident 1 stated Sec1 hit him on the back of the head and could not recall the date and time.</p> <p>During an interview on 6/23/2025 at 11:20 AM with Sec 1, Sec 1 stated CNA 1 was assisting Resident 1 and wheeling Resident 1 to his room. Sec 1 stated he (Sec1) went over to CNA 1 and Resident 1 because Resident 1 had been acting out. Sec 1 stated he (Sec1) tried to calm Resident 1 down and put his arm up to Resident 1 to say sorry to try to calm Resident 1 down. Sec 1 stated Resident 1 balled his fist and stated Resident 1 tried to hit him (Sec 1). Sec 1 stated he (Sec 1) raised his hand to protect himself/duck out of Resident 1's way to avoid getting hit by Resident 1.</p> <p>During a follow up interview on 6/23/2025 at 12:50 PM with Sec 1, Sec 1 stated did not receive abuse training (you learn how to protect people from being hurt or mistreated by others) from the facility and was employed with the security company on 6/16/2025. Sec 1 stated he just signed a bunch of papers.</p> <p>During an interview on 6/23/2025 at 12:55 PM with CNA 1, CNA 1 stated he (CNA1) was taking Resident 1 from the female side (the side of the facility where the women reside) during the evening shift on 6/19/2025 when Resident 1 got into an argument with Sec 1. CNA 1 stated he (CNA1) took Resident 1 back to the resident's room to get him away, from Sec 1 who followed Resident 1 and CNA 1 to Resident 1's room. CNA 1 stated Resident 1 was sitting in a wheelchair facing the drawers at the head of his bed. CNA 1 stated Resident 1 had his back to the doorway when Sec 1 came through the door and hit Resident 1 on the back of his head with an open palm. CNA 1 stated the sound the hit made was loud enough for the nurse outside (unidentified) of the room to ask what happened. CNA 1 stated he (CNA1) then told Sec 1 he (Sec1) should never hit any of the residents.</p> <p>During an interview on 6/23/2025 at 1:27 PM with Resident 1, Resident 1 stated when Sec1 hit Resident 1 (6/19/2025), the resident felt pain at a level of 8 out of 10 (a numerical scale used to assess pain intensity, where 0 indicates no pain and 10 represents the worst pain imaginable. 0-3 mild pain, 4-6 moderate pain, 7-9 severe pain, 10 worst pain imaginable) Resident 1 also reported feeling bad and embarrassed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/23/2025 at 1:44 PM with the Director of Nursing (DON) and the facility Administrator (Adm), the DON stated abuse training was required for all staff working at the facility as well as anyone working in the resident care area. The DON stated she (DON) only received verbal understanding that Sec 1 had received abuse training. The DON stated the Director of Staff Development (DSD) was responsible for verifying Sec 1's abuse training was completed. The DON stated the DSD was not at the facility because the DSD was sick. The DON stated if the DSD was not available then it would be DON's responsibility to verify Sec 1 received abuse training. The DON stated she met with Sec 1 on 6/9/2025 and Sec 1 received orientation from the DON who went over de-escalation tactics (ways to calm down a tense or potentially violent situation without using force) with Sec 1. The DON stated abuse training was part of the requirement for competent staffing (making sure your team has the right people with the right skills in the right places to get the job done well) and stated the alleged abuse by Sec 1 on Resident 1 could have been prevented.</p> <p>During a telephone interview on 7/3/2025 at 2:11 PM, with Registered Nurse (RN1), Resident 1's IDT Review General note dated 6/20/2025 at 11:20 AM was reviewed. RN1 stated the IDT Review General note indicated Resident 1 stated his head hurt and the Director of Nursing (DON) asked if the nurse (unidentified) gave him any medication for pain and the resident replied No. RN1 stated the IDT notes did not indicate the pain level of Resident 1's head pain. RN1 stated the IDT notes did not indicate Resident 1 received pain relief medication for head.</p> <p>During the concurrent telephone interview on 7/3/2025 at 2:37 PM, with RN1 Resident 1's Progress Notes for 6/20/2025 and the Medication Administration Record (MAR) for the month of June 2025 were reviewed. RN1 stated the Progress Notes and the (MAR) did not indicate Resident 1 received pain relief medication for head and did not indicate the pain level of Resident 1's head pain.</p> <p>During a review of the facility's P&P titled Abuse Prevention Program dated 1/16/2025, the P&P indicated Our residents have the right to be free from abuse, neglect, misappropriation of property (when someone uses money or property that doesn't belong to them for their own personal use or another unauthorized purpose, without permission from the actual owner) and exploitation (the act of using someone or something unfairly for one's own advantage). This includes but is not limited to freedom from corporal punishment (a punishment which is intended to cause physical pain to a person), involuntary seclusion (means being forced to stay in a room or confined space against your will, where you cannot leave), verbal, mental, sexual, or physical abuse and physical (limiting someone's movement) or chemical restraint (when medication is used to control a person's behavior, not because it's the right treatment for their condition, but to make them less active or easier to manage) not required to treat the resident's symptoms (what you feel or notice when you're sick or have a health problem). The P&P indicated the facility would protect our residents from abuse from anyone including, but not necessarily limited to: facility staff, other residents, consultants (a specialized expert brought in from outside to help a company or organization with a specific problem or goal), volunteers, staff from other agencies, family members, legal representatives (someone authorized to act on behalf of another person or entity in legal matters), friends, visitor, or any other individual (person). The P&P indicated the facility would require staff training/orientation (the initial period where a new hire gets introduced to the company, their team, and their specific job duties and helps them understand the company's culture, policies, and expectations, and get comfortable in their new role) programs that include such topics as abuse prevention, identification and reporting of abuse, stress management (learning to cope with stress in healthy ways), and handling verbally or physically aggressive resident behavior.</p>		