

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  02/18/2026
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to report to the State Survey Agency (SSA) within two hours of a resident-to-resident altercation for two of four sampled residents (Resident 1 and Resident 2). On 2/6/26 at 10:47 a.m., Resident 1 and Resident 2 had a verbal and physical altercation. The facility reported the incident to the SSA on 2/6/26 at 4:05 p.m. This deficient practice had the potential to under report alleged cases of resident abuse to the SSA and may delay the investigation to ensure Resident 1 and Resident 2 were safe. 1. During a review of the admission Record indicated the facility admitted Resident 1 on 5/25/23 and re-admitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), anxiety disorder and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) During a review of the Minimum Data Set (MDS, resident screening tool) dated 11/16/25 indicated Resident 1 had severely impaired cognitive skills. Resident 1 needed substantial assistance 9helper does more than half the effort) with shower/bathe self, upper body dressing and personal hygiene. Resident 1 needed partial assistance (helper does less than half the effort) with putting on/taking off footwear. The same MDS indicated Resident 1 needed supervision with lower body dressing and was independent with eating, oral hygiene and toileting hygiene. 2. During a review of the admission Record indicated the facility admitted Resident 2 on 12/4/24 with diagnoses including legal blindness, depression and generalized muscle weakness. During a review of the MDS dated [DATE] indicated Resident 2 was cognitively intact. Resident 2 needed set-up assistance (helper sets up or cleans up, resident completes activity) with toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear and personal hygiene. Resident 2 was independent with eating, oral hygiene and upper body dressing. During a review of the Behavior Related Incidents dated 2/6/26 at 10:47 a.m. indicated on 2/6/26 at 10:47 a.m., Resident 1 and Resident 2 were noted to be speaking to one another in an elevated tone. Staff attempted to de-escalate the interaction between Resident 1 and Resident 2. Resident 1 grabbed Resident 2 while four staff members were present. The Behavior Related Incident indicated the paramedics and the police were notified. Resident 1 and Resident 2 refused medical care from the paramedics. At 11:28 a.m., the police arrived and at 12:18 p.m., the police transferred Resident 1 to the general acute hospital (GACH) for further evaluation. During a review of the initial report dated 2/6/26 sent by facsimile (fax) to the SSA, indicated Resident 1 and Resident 2 had physical altercation on 2/6/26. During a review of the fax transmission Verification Report indicated the facility sent the initial report to the SSA on 2/6/26 at 4:05 p.m. During a concurrent interview and record review on 2/19/26 at 1:24 p.m., the facility's initial report and the facility's Abuse Policy were reviewed with the administrator (ADM). The ADM stated allegations of abuse should be reported to the SSA within two hours of the incident. The ADM confirmed that Resident 1 and Resident 2's altercation was sent to the SSA on 2/6/26 at 4:05 p.m. The ADM stated because Resident 1 had a diagnosis that included dementia and there was</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>no serious body injury, the incident between Resident 1 and Resident 2 could be reported to the SSA within 24 hours. During a review of the facility's policy and procedures (P&amp;P) titled Abuse Investigation and Reporting reviewed on 11/25/25 indicated all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. The same Policy indicated all alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: A. Two hours if the alleged violation involves abuse or has resulted in serious bodily injury; or B. Twenty-four hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.</p>		