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	06/25/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was protected from misappropriation of personal property by failing to safeguard Resident 1's debit card after identifying Resident 1 lacked the capacity to safely manage finances.This deficient practice resulted in Resident 1's debit card going missing while residing in the facility, unauthorized financial transactions, and psychosocial harm, as evidenced by Resident 1 reporting feeling upset, wanting to cry, and no longer feeling safe in the facility.During a review of Resident 1's admission Record, dated 4/7/2026, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality), depression (a mood disorder that may cause persistent sadness or loss of interest in activities), and anxiety (persistent feeling of dread or panic that can interfere with daily life) .During a review of Resident 1's Minimum Data Set (MDS- resident assessment tool), dated 5/5/2026, indicated Resident 1 had severe impaired cognition (ability to think, remember and reason) . Resident 1 required supervision (oversight, encouragement, or cueing) for eating, oral hygiene, toileting, shower/bath, upper and lower body dressing, putting on footwear, and personal hygiene. Resident 1 required partial assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) to roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed transfer, and walk 10 feet.During a review of Resident 1's Resident's Clothing and Possessions Inventory Checklist on Admission, dated 4/7/2026, indicated Resident had presented with 2 ATM (debit) cards to the facility, and CNA1 had verified these cards.During a review of Resident 1's Chase Bank Report, dated 6/4/2026, indicated Resident 1 reported unauthorized transactions on 6/1/2026 which included the following disputed transactions:5/1/2026 El [NAME] Loco in Los Angeles CA $13.715/1/2026 Popeyes in Gardena CA $48.585/7/2026 Kwik Serv Gas in Inglewood CA $18.375/7/2026 El [NAME] Loco in Inglewood CA $18.765/9/2026 VIP Bargain Center in Los Angeles CA $111.695/10/2026 Apparel women's ready to wear stores in Inglewood CA $94.615/12/2026 Acai Republic in [NAME] Beach CA $13.095/12/2026 Salvation Army in [NAME] Beach CA $30.975/12/2026 Ramen and Poke in [NAME] Beach CA $15.315/12/2026 Hobby Lobby in [NAME] CA $135.055/18/2026 Walmart subscription $7.105/19/2026 [NAME] Service Station in Los Angeles CA $12.505/19/2026 [NAME] Service Station in Los Angeles CA $40.005/23/2026 Ono fast food restaurants in Diamond Bar CA $21.93Total unauthorized purchases equaled to $581.67.During a phone interview on 6/25/2026 at 9 AM, the Care Coordinator (CC) for Resident 1, stated on 6/1/2026, she visited Resident 1 in the facility and noticed that Resident 1's debit card was missing from her wallet. The CC stated she assisted Resident 1 in paying her bills which includes paying her monthly rent for Resident 1's apartment, and she had come to assist Resident 1 in doing so on 6/1/2026. However, upon revision of Resident 1's inventory list, the CC noted that despite Resident 1's debit card being listed on the facility's inventory, her debit card was missing from her wallet, and the debit card had been unaccounted for from 5/15/2026 through 6/1/ 2026, and the debit card had been used without authorization from Resident 1. The CC (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
	055036	A. Building B. Wing	06/25/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she helped Resident 1 file a fraudulent report with the bank institution on 6/1/2026 to cancel Resident 1's debit card, and she notified the Social Services Director of the facility.During an interview on 6/25/2026 at 9:37 AM, the Social Services Director (SSD) stated that upon admission nursing staff are responsible for completing an inventory of resident belongings when Social Services is unavailable. The SSD stated valuables including money, jewelry, Social Security cards, credit cards, debit cards, and important documents are to be secured in the business office. The SSD stated if residents are confused, staff must use a witness and explain that valuables will be kept secured in the business office for safekeeping. If admission occurs on weekends, nursing staff are expected to secure the valuables until Social Services is available. The SSD stated she met with Resident 1 within two days of admission and recognized Resident 1 was confused and lacked the ability to independently manage her affairs. The SSD stated she referred Resident 1 to the Public Guardian for conservatorship due to concerns regarding the resident's inability to manage finances and absence of available family or responsible representatives. The SSD stated Resident 1 does not have privileges to go out on pass, nor does she drive, therefore Resident 1 could not have made the purchases that were made starting 5/1/2026 through 6/1/2026. During an interview on 6/25/2026 at 9:54 AM with Resident 1, Resident 1 was seated outside her room and stated that after learning her ATM card was missing, she wanted to cry and no longer felt safe in the facility. Resident 1 stated she could not think of anyone who would have taken the card, had not witnessed anyone searching through her belongings, and had not given the card to anyone. Resident 1 stated she believed she had kept her wallet with her and thought it was safe in her room. Resident 1 stated she became aware the ATM card was missing only after her case worker requested the card to make a payment for her apartment and the card could not be located. Resident 1 stated her Case Worker helped her report the debit card missing to her bank to cancel further unauthorized transactions. During a phone interview on 6/25/2026 at 10:01 AM, Certified Nursing Assistant (CNA) 1 stated he completed Resident 1's admission inventory independently. CNA 1 stated Resident 1 wanted to keep her wallet, and because he believed she was oriented, he allowed her to retain possession of it. CNA 1 stated he documented the inventory and provided the inventory sheet to the charge nurse but did not inform nursing that Resident 1 retained possession of her wallet or valuables. CNA 1 further stated he later realized Resident 1 was confused and acknowledged no one informed him of her cognitive impairment during admission.During an interview on 6/25/2026 at 10:14 AM, the SSD stated the admission inventory documented Resident 1's debit card, confirming it was present upon admission. The SSD stated the missing debit card indicated it was lost while Resident 1 resided in the facility. The SSD further stated she initiated reports to Adult Protective Services (APS), the Ombudsman, law enforcement, and requested copies of Resident 1's bank statements after learning the debit card was missing. The SSD stated she did not report to California Department of Public Health, as she had notified the Administrator of the situation on 6/1/2025, who was the Abuse Coordinator for the facility. The SSD stated the facility was responsible for reimbursing Resident 1 for the total amount of purchases that were made without Resident 1's authorization after her debit card was stolen. During an interview on 6/25/2026 at 10:47 AM, CNA 2 stated CNAs are expected to inventory valuables with a witness and notify the charge nurse or Social Services if a resident wishes to retain money or valuables so that they can identify and account for those valuables. During an interview on 6/25/2026 at 10:51 AM, the Director of Staff Development (DSD) stated the admission inventory documented Resident 1's debit card upon admission. The DSD stated the debit card later went missing while Resident 1 resided in the facility. The DSD stated CNA 1 reported Resident 1 wanted to keep her wallet because he believed she was alert and oriented. The DSD stated CNA 1 should have notified nursing regarding the valuables, and licensed nursing staff should have verified which valuables Resident 1 retained. The DSD further stated valuables should have been secured in the business office and, if the resident refused, nursing staff should have documented the refusal. During an interview on 6/25/2026 at 11:04 AM, the Registered Nurse (RN) Supervisor stated licensed nurses are responsible for securing (continued on next page)

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	06/25/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident valuables in a locked narcotic drawer until transferred to the business office. The RN Supervisor stated CNA 1 did not report that Resident 1 wished to retain her wallet or debit cards. The RN Supervisor stated if a resident refuses to relinquish valuables, nursing staff should follow facility policy by attempting to secure the items and documenting the resident's refusal.During an interview on 6/25/2026 at 11:21 AM, the Administrator stated he was aware of Resident 1's missing debit card and suspected financial exploitation beginning on 6/1/2026. The Administrator acknowledged he did not report the allegation to the California Department of Public Health because he believed the SSD had already completed the required reporting. The Administrator stated this incident was a form of financial abuse and the facility would implement an internal investigation and plan of correction moving forward starting 6/25/2026. The Administrator did not indicate that an internal investigation had been initiated at the time the allegation was identified on 6/1/2026, as he was pending Bank Statement Reports from the Care Coordinator.During a review of the facility's policy and procedure (P&P) titled Personal Property, dated 11/25/2025, indicated a representative of the admitting office will advice the resident, prior to or upon admission, as to the types and amount of personal clothing and possessions that the resident may keep in his or her room. The facility will promptly investigate any complaints of misappropriation or mistreatment of resident property.During a review of the facility's P&P titled Admitting the Resident: Role of the Nursing Assistant dated 11/25/2025, indicated to inventory the resident's personal effects ask the family member to remain in the room to witness the inventory of all clothing, valuables, and give the inventory of personal effects record to the nurse supervisor.

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	06/25/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its' policy and procedures (P&P) titled Abuse Investigation and Reporting dated 11/25/2025 by failing to report the misappropriation of property (Debit Card) for one of three sampled residents' (Resident 1).This deficient practice resulted in multiple unauthorized transactions on 6/1/2026 on Resident 1's debit cards. During a review of Resident 1's admission Record, dated 4/7/2026, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality), depression (a mood disorder that may cause persistent sadness or loss of interest in activities), and anxiety (persistent feeling of dread or panic that can interfere with daily life) .During a review of Resident 1's Minimum Data Set (MDS- resident assessment tool), dated 5/5/2026, indicated Resident 1 had severe impaired cognition (ability to think, remember and reason) . Resident 1 required supervision (oversight, encouragement, or cueing) for eating, oral hygiene, toileting, shower/bath, upper and lower body dressing, putting on footwear, and personal hygiene. Resident 1 required partial assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) to roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed transfer, and walk 10 feet.During a review of Resident 1's Resident's Clothing and Possessions Inventory Checklist on Admission, dated 4/7/2026, indicated Resident had presented with 2 ATM (debit) cards to the facility, and CNA1 had verified these cards.During a review of Resident 1's Chase Bank Report, dated 6/4/2026, indicated Resident 1 reported unauthorized transactions on 6/1/2026 which included the following disputed transactions:5/1/2026 El [NAME] Loco in Los Angeles CA $13.715/1/2026 Popeyes in Gardena CA $48.585/7/2026 Kwik Serv Gas in Inglewood CA $18.375/7/2026 El [NAME] Loco in Inglewood CA $18.765/9/2026 VIP Bargain Center in Los Angeles CA $111.695/10/2026 Apparel women's ready to wear stores in Inglewood CA $94.615/12/2026 Acai Republic in [NAME] Beach CA $13.095/12/2026 Salvation Army in [NAME] Beach CA $30.975/12/2026 Ramen and Poke in [NAME] Beach CA $15.315/12/2026 Hobby Lobby in [NAME] CA $135.055/18/2026 Walmart subscription $7.105/19/2026 [NAME] Service Station in Los Angeles CA $12.505/19/2026 [NAME] Service Station in Los Angeles CA $40.005/23/2026 Ono fast food restaurants in Diamond Bar CA $21.93Total unauthorized purchases equaled to $581.67.During a phone interview on 6/25/2026 at 9 AM, the Care Coordinator (CC) for Resident 1, stated on 6/1/2026, she visited Resident 1 in the facility and noticed that Resident 1's debit card was missing from her wallet. The CC stated she assisted Resident 1 in paying her bills which includes paying her monthly rent for Resident 1's apartment, and she had come to assist Resident 1 in doing so on 6/1/2026. However, upon revision of Resident 1's inventory list, the CC noted that despite Resident 1's debit card being listed on the facility's inventory, her debit card was missing from her wallet, and the debit card had been unaccounted for from 5/15/2026 through 6/1/ 2026, and the debit card had been used without authorization from Resident 1. The CC stated she helped Resident 1 file a fraudulent report with the bank institution on 6/1/2026 to cancel Resident 1's debit card, and she notified the Social Services Director of the facility.During an interview on 6/25/2026 at 9:37 AM, the Social Services Director (SSD) stated that upon admission nursing staff are responsible for completing an inventory of resident belongings when Social Services is unavailable. The SSD stated valuables including money, jewelry, Social Security cards, credit cards, debit cards, and important documents are to be secured in the business office. The SSD stated if residents are confused, staff must use a witness and explain that valuables will be kept secured in the business office for safekeeping. If admission occurs on weekends, nursing staff are expected to secure the valuables until Social Services is available. The SSD stated she met with Resident 1 within two days of admission and recognized Resident 1 (continued on next page)

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	06/25/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was confused and lacked the ability to independently manage her affairs. The SSD stated she referred Resident 1 to the Public Guardian for conservatorship due to concerns regarding the resident's inability to manage finances and absence of available family or responsible representatives. The SSD stated Resident 1 does not have privileges to go out on pass, nor does she drive, therefore Resident 1 could not have made the purchases that were made starting 5/1/2026 through 6/1/2026. During an interview on 6/25/2026 at 9:54 AM with Resident 1, Resident 1 was seated outside her room and stated that after learning her ATM card was missing, she wanted to cry and no longer felt safe in the facility. Resident 1 stated she could not think of anyone who would have taken the card, had not witnessed anyone searching through her belongings, and had not given the card to anyone. Resident 1 stated she believed she had kept her wallet with her and thought it was safe in her room. Resident 1 stated she became aware the ATM card was missing only after her case worker requested the card to make a payment for her apartment and the card could not be located. Resident 1 stated her Case Worker helped her report the debit card missing to her bank to cancel further unauthorized transactions. During a phone interview on 6/25/2026 at 10:01 AM, Certified Nursing Assistant (CNA) 1 stated he completed Resident 1's admission inventory independently. CNA 1 stated Resident 1 wanted to keep her wallet, and because he believed she was oriented, he allowed her to retain possession of it. CNA 1 stated he documented the inventory and provided the inventory sheet to the charge nurse but did not inform nursing that Resident 1 retained possession of her wallet or valuables. CNA 1 further stated he later realized Resident 1 was confused and acknowledged no one informed him of her cognitive impairment during admission. During an interview on 6/25/26 at 10:14 AM, the Social Services Director (SSD) stated Resident 1's debit card was listed on the admission inventory but was later discovered missing while Resident 1 resided in the facility, which constituted financial abuse. The SSD stated she reported the allegation to Adult Protective Services and the Ombudsman on 6/1/26, contacted law enforcement, and requested bank statements documenting unauthorized transactions. During an interview on 6/25/26 at 11:21 AM, the Administrator stated he was aware of the missing debit card and suspected financial exploitation beginning on 6/1/26. The Administrator acknowledged and stated he did not report the allegation to the California Department of Public Health because he believed the Social Services Director had already completed the required reporting. The Administrator stated he did not have an internal investigation documented nor had the investigation been initiated at the time the allegation was identified on 6/1/2026. During a review of the facility's P&P titled Abuse Investigation and Reporting dated 11/25/2025 indicated all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and or injuries of unknown source shall be reported immediately but not later than 2 hours if alleged violation involves abuse OR has resulted in bodily injury, or 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury to local, state, and federal agencies and thoroughly investigated by facility management. The administrator will assign the investigation to an appropriate individual. Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the administrator.The individual conducting the investigation will as a minimum:Review the completed documentation formsReview the resident's medical record to determine events leading up to the incidentInterview the person reporting the incidentInterview any witnessesInterview residentInterview staff members who have had contact with the resident during the period of the alleged incidentReview all events leading up to the alleged incident.