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	07/11/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to ensure residents do not self-administer medications without prior approval by allowing one of five residents observed for medication administration (Resident 19) to self-administer fluticasone (a medication used to treat allergies) nasal spray without an interdisciplinary team (IDT - a multi-discipline group of healthcare professionals involved in periodically meeting and planning care for individual residents) evaluation or a physician's approval. The deficient practice of allowing Resident 19 to self-administer medication without an IDT evaluation for safety or physician's order increased the risk that he may have administered the wrong dose of fluticasone due to poor technique possibly resulting in medical complications. Findings: During an observation on 7/9/24 at 8:40 AM, Resident 19 was observed self-administering Fluticasone (Flonase) nasal spray prepared by the licensed vocational nurse (LVN 2). A review of Resident 19's Admission Record indicated he was admitted to the facility on [DATE] with diagnoses including anxiety disorder (a mental health disorder characterized by feeling or worry or fear that are strong enough to interfere with daily activities). A review of Resident 19's History and Physical dated 5/9/24, indicated he was not competent to understand his medical condition. A review of Resident 19's Order Summary Report dated 5/31/24, indicated he was prescribed Flonase nasal spray to administer one spray in each nostril one time a day for allergic rhinitis (allergies) to be clinician administered. A review of Resident 19' Self-Administration of Medication Evaluation, dated 5/26/23, indicated Resident 19 did Not wish to self-administer medications. A review of Resident 19's clinical record indicated there was no documentation from an IDT evaluation or physician's order indicating it was safe for Resident 19 to administer his own medications. (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: 055036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Maple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2625 Maple Ave. Los Angeles, CA 90011	

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/9/24 at 9:52 AM, LVN 2 stated she allowed Resident 19 to administer his own Flonase nasal spray this morning because it was his preference. LVN 2 stated there was no prior approval or physician's order for Resident 19 to self-administer fluticasone. LVN 2 stated Resident 19's Flonase was supposed to be clinician administered rather than self-administered. LVN 2 stated when an order was listed for clinician administered for any medication requiring any form of technique, she would be required to don gloves, instruct the resident on how to prepare, and administer the dose personally to the resident. LVN 2 stated allowing residents to self-administer without any sort of evaluation for safety increased the risk that they may administer the wrong dose of the medication due to poor technique possibly resulting in medical complications. A review of the facility's policy titled, Administering Medications, revised April 2019, indicated medications were administered in a safe and timely manner, and as prescribed. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, have determined that they have the decision-making capacity to do so safely. A review of the facility's policy titled, Self-Administration of Medications, last revised February 2021, indicated residents had the right to self-administer medication when the interdisciplinary team had determined that it was clinically appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment, the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medication was safe and clinically appropriate for the resident. If it was deemed safe and appropriate for a resident to self-administer medication, this was documented in the medical record and care plan.

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F 0600 Level of Harm - 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** 44309 Based on interview and record review, the facility failed to protect the resident's right to be free from abuse (deliberate, aggressive, or violent behavior with the intention to cause harm) for two of three sampled residents (Resident 5 and Resident 35). The facility failed to: -Ensure Resident 5 was free from physical abuse and was not struck in the face by Resident 206 with an open hand on 6/23/2024. -Prevent Resident 206 from splashing coffee onto Resident 35 on 6/3/2024, when Resident 206 had an aggressive behavior, was angry and upset. and splashed coffee onto another resident (Resident 35). These deficient practices resulted in Resident 5 and Resident 35 being subjected to abuse and psychosocial (mental health) harm by Resident 206, while under the care of the facility. Resident 5 asked the police to take Resident 206 away. Findings: A review of Resident 206's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including schizophrenia (a serious mental disorder in which people interpret reality abnormally), bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), Parkinson disease (a brain condition that causes problems with movement, mental health, sleep, pain and other health issues), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 206's History and Physical (H&P) dated 5/9/2024, indicated the resident was not competent to understand her medical condition. A review of Resident 206's Care Plan for the Alteration in Psychosocial Well-being related to schizophrenia and bipolar disease initiated on 5/9/2024, indicated Resident 206 had a history of self-harm. The care plan goal was for the resident to show gradual positive progress towards interacting with others for the next three months. The care plan interventions indicated to allow the resident to verbalize feelings, concerns, or fears, to identify issues causing stress to the resident, address issues of concerns, identify issues important to the resident and offer social services assistance if needed, and to encourage active involvement in activities for socialization and stimulation. A review of Resident 206's Care Plan for Bipolar disorder initiated on 5/11/2024, indicated the goal for the resident was to not have injuries to herself or others during outbursts for three months. The care plan interventions indicated to monitor the resident for signs of impeding violence such as increasing activities, clenching fists, teeth and to keep the resident away from proximity of others, if above symptoms were exhibited, to provide diversional activities to keep the resident occupied and to review medications and diagnoses for possible causes of behaviors and address issues of concerns. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	According to a review of Resident 206's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 5/14/2024, the resident's cognitive skills (ability to think, remember and make decisions) for daily decision making was intact, but had trouble concentrating on things such as reading the newspaper. The MDS indicated Resident 206 had trouble falling or staying asleep, was feeling tired or having little energy, and did not display any psychosis (symptoms that happen when a person was disconnected from reality) behavior. A review of Resident 206's Nursing Progress Note dated 6/2/2024 at 9:45 AM, indicated the resident was being monitored for aggressive behavior, was redirected at times during the shift, and was re-educated on appropriate behaviors in activity room and hallways. A review of Resident 206's Social Service Note dated 6/3/2024 at 1:54 PM, indicated the resident was being monitored for aggressive behavior, as the resident got angry and upset and splashed coffee onto another resident (Resident 35). The note indicated Resident 206's conservator (a person appointed by the court to make decisions about personal matters for a person who is not able to make his/her own decision, including decisions about medical care, food, clothing, where the person will live) and psychiatric doctor (a medical practitioner specializing in the diagnosis and treatment of mental illness) were made aware. This social service note was stricken by Social Services Director (SSD) on 6/24/2024 at 3:57 PM, and was marked as incorrect documentation. A review of Resident 206's Change of Condition - SBAR Form (Situation-Background-Assessment and Recommendation - a written communication tool that helps provide important information) dated 6/23/2024 at 1:05 PM, indicated Resident 206 displayed aggressive behavior towards her roommate (Resident 5). According to a review of the Nursing Progress Note dated 6/23/2024 at 2:23 PM, Resident 206 assaulted (hit in the face with an open hand) another resident (Resident 5) at 2 PM, the Police Department arrived at the facility and arrested Resident 206 for assault. A review of Resident 5's Admission Record indicated the facility readmitted the resident on 1/10/2024, with diagnoses including dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Parkinson disease (a brain condition that causes problems with movement, mental health, sleep, pain and other health issues), and anxiety disorder (a mental health disorder characterized by feelings of worry, or fear that are strong enough to interfere with one`s daily activities). A review of Resident 5's MDS dated [DATE], indicated the resident's cognitive skills for daily decision making was moderately impaired (decisions poor, cues/supervision required). A review of Resident 5's History and Physical (H&P) dated 5/31/2024, indicated that the resident had the capacity to understand and make decisions. A review of Resident 5's Nursing Progress Notes dated 6/23/2024 at 2 PM, indicated the resident was struck three times with an open hand by her roommate (Resident 206). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	According to a review of Resident 5's Nursing Progress Notes dated 6/23/2024 at 2:25 PM, on 6/23/2024 at around 2 PM, Resident 5 was walking out of her room while Resident 206 was standing by at the front of the door. Resident 5 wanted to pass through the door and asked to be excused and Resident 206 did not respond. The note further indicated that Resident 206 hit Resident 5 for no reason. A review of Resident 35's Admission Record indicated the facility readmitted the resident on 5/15/2023, with diagnoses including dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and schizoaffective disorder (a mental illness that can affect your thoughts, mood, and behavior). A review of Resident 35's MDS dated [DATE], indicated the resident's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). A review of Resident 35's History and Physical (H&P) dated 5/9/2024, indicated the resident was not competent to understand her medical condition. During an interview on 7/10/2024 at 8:30AM, inside Resident 5's room, with Certified Nursing Assistant (CNA) 4, Resident 5 stated she never had any issues with any of her roommates. During a concurrent interview at 8:40 AM, Resident 5 asked CNA 4 Why did Resident 206 hit me? Resident 5 stated, She just did not like me. CNA 4 stated, On 6/23/2024, in the afternoon Resident 5 asked me for toothpaste and a brush. I went to the supply room at the end of the hallway. When I looked back, I saw Resident 5 was standing at her door and Resident 206 was standing in the hallway. I witnessed Resident 206 hit Resident 5 three times one on her head, one on her cheek and one on her neck. When the police came Resident 5 asked the police to take her (Resident 206) away. During an interview on 7/10/2024 at 10:45 AM, Licensed Vocational Nurse (LVN) 1 stated, Resident 206 had behavioral issues, and was extremely frustrated because she did not receive her monthly money from her conservator. LVN 1 stated Resident 206 was Resident 5's roommate and on 6/23/2024, Resident 5 and Resident 206 were talking in the hallway next to their room, in a verbal altercation. Then Resident 206 started hitting Resident 5 three times with an open hand. LVN 1 stated Resident 5 requested the police to come. Resident 5 kept saying she wanted to call the police. Resident 206 stated she was going to do it again. The police came and arrested Resident 206 for an assault. On 7/10/2024 at 11:26 AM, during an interview, the Social Services Director (SSD) stated Resident 206 was involved in another resident-to-resident altercation before 6/23/2024. The SSD stated Resident 206 threw coffee at another resident (Resident 35), but did not remember which resident. The SSD further stated, On 6/2/2023, both residents were in the activity room. Resident 206 got upset and she threw coffee at the other resident (Resident 35). I made some notes in Resident 206's chart regarding her aggressive behavior on 6/2/2024, however, I deleted the notes because a lot had happened, and I wanted to add some more information. The SSD stated licensed staff did not develop a change of condition - SBAR for this incident for Resident 206. The SSD stated, The other affected resident was not monitored for any emotional distress after the incident. During an interview on 7/10/2024 at 11:49 AM, CNA 5 stated, I heard that Resident 206 threw coffee at another resident on 6/2/2024. In the morning huddle we were told to keep a close eye on Resident 206. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/10/2024 at 11:57 AM, LVN 3 stated, Resident 206 was alert, ambulatory and a smoker. She had days that she was calm and days that she was mad. Resident 206 would throw coffee and food on the floor. During a telephone interview on 7/10/2024 at 12:41 PM, the Activity Assistant (AA) stated on Sunday 6/2/2024 at around 5 PM, Resident 206 threw coffee at Resident 35 inside the activity room. AA stated, I asked her why she did it and she did not answer. We had to call a charge nurse to check Resident 35. Resident 35 was assessed, and was fine. During an interview on 7/10/2024 at 1:02 PM, inside Resident 35's room, Resident 35 stated that Resident 206 threw coffee at him. Resident 35 stated he was sitting in activity room and Resident 206 threw coffee at him for no reason. He stated the coffee hit him at his chest, face and in his eyes. He stated the coffee was not hot and he did not get burned. Resident 35 stated, I did not tell Resident 206 anything because she was a girl. I just let it go. On 7/10/2024 at 2 PM, during an interview, the facility's Director of Nursing (DON) stated Resident 5 did not sustain any injuries and she verbalized that she was feeling safe in the facility. Resident 206 was removed from the facility by the police. The DON stated, I have a binder and there is documentation regarding Resident 206 throwing coffee at another resident on 6/2/2024. However, the incident was not documented as an allegation of abuse. The DON stated he was not sure what interventions were done for Resident 206 after the incident on 6/2/2024. During an interview on 7/10/2024 at 2:20PM, the facility's Administrator (ADM) stated that the incident on 6/2/2024, between Resident 206 and Resident 35 was not reported to the Department, ombudsman, or the police department. The ADM stated this was a reportable incident. The ADM stated she was in charge of reporting the allegation of physical abuse between Resident 206 and Resident 35. The ADM stated, The potential outcome of not reporting a resident-to-resident physical altercation is a delay in the investigation and delivery of necessary interventions to ensure resident safety. A review of the facility's documentation of its Leadership Staff dated from 10/2023 to 6/27/2024 indicated the facility had an Interim DON working at the time of this incident and an Interim Administrator was also working during this incident. The Interim Administrator last day was 6/3/2024, and the abuse was not reported or investigated. A review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation and Misappropriation Prevent Program, reviewed April 2024, indicated residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. Investigate and report any allegation within timeframe required by federal requirements. Protect residents from further harm during investigation. Implement measures to address factors that may lead to abusive situations. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Abuse Prevention Program, reviewed 4/11/2024, indicated as a part of abuse prevention, the administration will protect our residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Identify and assess all possible incidents of abuse. Investigate and report any allegations of abuse within timeframes as required by federal requirements.

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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** 44309 Based on interview and record review, the facility failed to report a resident-to-resident altercation to the State Survey Agency (SSA) within the appropriate time frame for two of three sampled residents (Resident 35 and Resident 206). This deficient practice resulted in a delay of onsite inspections by the Department of Public Health (DPH) and placed the residents at risks of further abuse (inappropriate treatment of an individual). Findings: A review of Resident 206's Admission Record indicated the facility admitted the resident on 5/8/2024, with diagnoses including schizophrenia (a serious mental disorder in which people interpret reality abnormally), bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), Parkinson disease (a brain condition that causes problems with movement, mental health, sleep, pain and other health issues), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 206's History and Physical (H&P) dated 5/9/2024, indicated the resident was not competent to understand her medical condition. A review of the Alteration in Psychosocial Well-being Care Plan related to schizophrenia and bipolar disease initiated on 5/9/2024, indicated Resident 206 had history of self-harm. The care plan goal was for the resident to show gradual positive progress towards interacting with others for the next three months. The care plan interventions indicated to allow the resident to verbalize feelings, concerns, or fears, to identify issues causing stress to the resident, address issues of concerns, identify issues important to the resident and offer social services assistance if needed, and to encourage active involvement in activities for socialization and stimulation. According to a review of Resident 206's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 5/14/2024, the resident's cognitive skills (ability to think, remember and make decisions) for daily decision making was intact, but had trouble concentrating on things such as reading the newspaper. The MDS indicated Resident 206 had trouble falling or staying asleep, was feeling tired or having little energy, and did not display any psychosis (symptoms that happen when a person was disconnected from reality) behavior. A review of Resident 206's Nursing Progress Note dated 6/2/2024 at 9:45 AM, indicated the resident was being monitored for aggressive behavior, was redirected at times during the shift, and was re-educated on appropriate behaviors in activity room and hallways. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 206's Social Service Note dated 6/3/2024 at 1:54 PM, indicated the resident was being monitored for aggressive behavior, as the resident got angry and upset and splashed coffee onto another resident. The note indicated Resident 206's conservator (a person appointed by the court to make decisions about personal matters for a person who is not able to make his/her own decision, including decisions about medical care, food, clothing, where the person will live) and psychiatric doctor were made aware. This social service note was stricken by Social Services Director (SSD) on 6/24/2024 at 3:57 PM, and was marked as incorrect documentation. A review of Resident 35's Admission Record indicated the facility readmitted the resident on 5/15/2023, with diagnoses including dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and schizoaffective disorder (a mental illness that can affect your thoughts, mood, and behavior). A review of Resident 35's MDS dated [DATE], indicated the resident's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). During an interview on 7/10/2024 at 11:26 AM, the Social Services Director (SSD) stated Resident 206 was a young resident who had episodes of aggression and would snap. (SSD) stated Resident 206 was involved in another resident-to-resident altercation before 6/23/2024. The SSD stated Resident 206 threw coffee at another resident (Resident 35), but did not remember which resident. The SSD further stated, On 6/2/2023, both residents were in the activity room. Resident 206 got upset and she threw coffee at the other resident (Resident 35). I made some notes in Resident 206's chart regarding her aggressive behavior on 6/2/2024, however, I deleted the notes because a lot had happened, and I wanted to add some more information. The SSD stated this incident is considered a physical altercation and was a reportable incident. The SSD stated, I did not report this incident to Department of Public Health (DPH), Ombudsman (government employee who investigates and tries to resolve complaints), and the police. The SSD stated this incident was not investigated by any agencies. The SSD stated the potential outcome of not reporting an allegation of resident-to-resident altercation was the delay of the investigation by the appropriate agencies and harm to the residents. During an interview on 7/10/2024 at 11:49 AM, CNA 5 stated, I heard that Resident 206 threw coffee at another resident on 6/2/2024. In the morning huddle we were told to keep a close eye on Resident 206. During an interview on 7/10/2024 at 11:57 AM, LVN 3 stated, Resident 206 was alert, ambulatory and a smoker. She had days that she was calm and days that she was mad. Resident 206 would throw coffee and food on the floor. During a telephone interview on 7/10/2024 at 12:41 PM, the Activity Assistant (AA) stated on Sunday 6/2/2024 at around 5 PM, Resident 206 threw coffee at Resident 35 inside the activity room. AA stated, I asked her why she did it and she did not answer. We had to call a charge nurse to check Resident 35. Resident 35 was assessed, and he was fine. What was done for Resident 206? (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/2024 at 2 PM, during an interview, the facility's Director of Nursing (DON) stated Resident 5 did not sustain any injuries and she verbalized that she was feeling safe in the facility. Resident 206 was removed from the facility by the police. The DON stated, I have a binder and there is documentation regarding Resident 206 throwing coffee at another resident on 6/2/2024. However, the incident was not documented as an allegation of abuse. The DON stated he was not sure what interventions were done for Resident 206 after the incident on 6/2/2024. During an interview on 7/10/2024 at 2:20 PM, the facility's Administrator (ADM) stated the incident on 6/2/2024, between Resident 206 and Resident 35 was not reported to CDPH, ombudsman, or the police department. The ADM stated this was a reportable incident. The ADM stated she began working in the facility from 6/3/2024, so she was not an employed Administrator when the incident between Resident 206 and Resident 35 occurred. The ADM stated the potential outcome of not reporting a resident-to-resident physical altercation was a delay in the investigation and delivery of necessary interventions to ensure resident safety. A review of the facility's documentation of it's Leadership Staff dated from 10/2023 to 6/27/2024 indicated the facility had an Interim DON working at the time of this incident and an Interim Administrator was also working during this incident. The Interim Administrator last day for 6/3/2024, and the abuse was not reported or investigated. A review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation and Misappropriation Prevent Program, reviewed April 2024, indicated residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. Investigate and report any allegation within timeframe required by federal requirements. Protect residents from further harm during investigation. Implement measures to address factors that may lead to abusive situations. A review of the facility's policy and procedure titled, Abuse Prevention Program, reviewed 4/11/2024, indicated as a part of abuse prevention, the administration will protect our residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Identify and assess all possible incidents of abuse. Investigate and report any allegations of abuse within timeframes as required by federal requirements. A review of the facility's policy and procedure titled, Abuse Investigation and Reporting, revised July 2017, indicated all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of an unknown origin source and misappropriation of property will be reported by the facility's Administrator, or his/her designee, to the following persons or agencies: the State licensing/certification agency responsible for surveying/licensing the facility, the local/State ombudsman, the resident's representative, adult protective services, law enforcement officials, the resident's attending physician and the facility's medical director. An alleged violation of abuse, neglect, exploitation, or mistreatment will be reported immediately, but no later than two hours if the allegation involves abuse or has resulted in serious bodily injury, or 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.

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NAME OF PROVIDER OR SUPPLIER Maple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2625 Maple Ave. Los Angeles, CA 90011	

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 44309 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - a standardized assessment and carescreening tool) was transmitted timely to the Centers for Medicare and Medicaid Services (CMS) system for one sampled resident (Resident 29). This deficient practice had the potential to result in delayed services for the resident. Findings: A review of Resident 29's Admission Record indicated the facility admitted the resident on 2/4/2023, with diagnoses including anxiety disorder (a condition in which a person has excessive worry and feelings of fear), and insomnia (a sleep disorder in which you have trouble falling and/or staying asleep). A review of Resident 29's MDS initiated on 3/7/2024, indicated the reason for this assessment was Resident 29's discharge, that the discharge was planned, and the assessment was completed on 7/9/2024. A review of the Physician's Order dated 3/7/2024, indicated Resident 29 was clear for discharge from the facility on 3/7/2024 at 3 PM. A review of Resident 29's Discharge Summary Report dated 3/7/2024, indicated the resident was discharged to a lower level of care (facilities for residents who need minimal assistance) on 3/7/2024. During a concurrent interview and record review on 7/10/2024 at 1:24 PM, with the MDS Coordinator (MDS), Resident 47's MDS assessments were reviewed. The MDS Coordinator stated it was required to complete a MDS assessment when a resident was being discharged from the facility. We have 14 days to complete the discharge MDS. Resident 47 was discharged from the facility on 3/7/2024, however the MDS for discharge was completed on 7/9/2024. The MDS Coordinator further stated, I completed Resident 47's discharge assessment on 7/9/2024, because it was incomplete, and it was open. I do not know why it was not completed. The potential outcome of not completing discharge MDS assessment on time was a delay in care and payment. A review of the facility's policy and procedure titled, Resident Assessment, revised November 2019, indicated a comprehensive assessment of every resident's needs was made at intervals designed by Omnibus Budget Reconciliation Act (OBRA- a set of national minimum set of standards of care and rights for people living in certified nursing facilities) and Prospective Payment System (PPS- a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount) requirements.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on interview and record review, the facility failed to accurately complete the minimum data set (MDS - a comprehensive resident assessment and care screening tool) assessment Section N (medications) on 3/28/24 by failing to indicate the resident's routine use of antipsychotic medication (medications used to treat mental illness) in one of five residents sampled for unnecessary medications (Resident 35.) The deficient practice of failing to accurately assess and indicate Resident 35's routine use of antipsychotic medication on the MDS comprehensive assessment Section N increased the risk that Resident 35 may not have received care planning and treatment according to his needs possibly leading to a decline in his overall health and well-being. Findings: A review of Resident 35's Admission Record dated 7/9/24, indicated he was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including dementia (a group of conditions characterized by a decline in mental function including memory loss and judgement) and schizoaffective disorder (a mental illness characterized by hearing and seeing things that are not there, believing things that are not true, and mood swings.) A review of Resident 35s History and Physical dated 5/9/24, indicated he was not competent to understand his medical condition. A review of Resident 35's Order Summary Report dated 5/31/24, indicated on 5/7/24, Resident 35 was prescribed Seroquel (an antipsychotic medication used to treat mental illness) 37.5 milligrams (mg - a unit of measure for mass) three times a day related to schizoaffective disorder. Further review of Resident 35's Physician's Orders indicated he had been using Seroquel regularly since his admission to the facility. A review of Resident 35's MDS comprehensive assessment Section N, dated 3/28/24, indicated Resident 35 was assessed as antipsychotics were not received. During an interview on 7/10/24 at 10 AM with the Director of Nursing (DON), the DON stated the MDS Section N completed on 3/28/24 for Resident 35 was incorrect, as it indicated Resident 35 did not receive antipsychotic medications. The DON stated it was clear from the medical record that Resident 35 was receiving antipsychotics throughout his stay at the facility. The DON stated the MDS assessment should read that Resident 35 received antipsychotics on a regular basis and was recorded incorrectly. The DON stated failure to complete the MDS accurately could affect the accuracy and completeness of care planning for the resident which could negatively affect his quality of life. A review of the facility's policy titled, Resident Assessments, revised November 2019, indicated a comprehensive assessment of every resident's need was made and intervals designated by OBRA and PPS requirements. The resident assessment coordinator was responsible for ensuring that the interdisciplinary team conducts timely and appropriate residents assessments. A comprehensive assessment included completion of the Minimum Data Set (MDS).

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 44309 Based on interview and record review, the facility failed to develop a baseline care plan for one of two sampled residents (Resident 47) within 48 hours of resident's admission. This deficient practice had the potential for delayed administration of necessary care and services. Findings: A review of Resident 47's Admission Record (Face Sheet) indicated the facility admitted the resident on 2/7/2024, with diagnoses including anxiety disorder (a condition with excessive worry and fear that interferes with daily activities), and dementia (loss of the ability to think, remember, and reason to levels that affect daily life and activities). A review of Resident 47's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 5/13/2024, indicated the resident's cognitive skills (ability to think, remember and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 47 was independent for eating, oral hygiene, toileting hygiene, upper and lower body dressing, showering/bathing, and personal hygiene. A review of Resident 47's History and Physical (H&P) dated 2/8/2024, indicated the resident was currently competent but had a history of intermittent (on and off) confusion, which may impair (weaken) understanding. During a concurrent interview and record review, on 7/9/2024 at 9:35 AM, with the Licensed Vocational Nurse (LVN) 2, Resident 47's baseline care plan was reviewed. LVN 2 stated staff started to complete Resident 47's base line care plan on 2/7/2024. However, base line care plan's general information and initial goal sections were not completed. LVN 2 stated Resident 47's base line care plan was not complete. LVN 2 stated licensed nurses were required to complete a resident's base line care plan within 72 hours of admission. LVN 2 stated the potential outcome of not completing resident's base line care plan thoroughly and on time was the inability to meet resident's immediate care needs and lack of care. During an interview on 7/11/2024 at 12:21 PM, with the Director of Nursing (DON), the DON stated a resident's base line care plan was required to be completed within 48 hours of resident's admission to the facility. The DON stated Resident 47's base line care plan was not completed upon admission. A review of the facility's policy and procedure titled, Care Plans-Baseline, revised December 2016, indicated a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. The interdisciplinary Team (IDT- a group of health care professionals who work together to provide care) will review the healthcare practitioner's orders and implement a baseline care plan to meet the resident's immediate care needs including, but not limited to the following: initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview and record review, the facility failed to develop individualized comprehensive person-centered care plan to meet the resident's needs for two of five sampled residents (Resident 8 and Resident 26) as evidenced by: -Failing to create a comprehensive care plan to address problematic behaviors of auditory and visual hallucinations seeing and hearing voices of people that are not there related to the use of risperidone (a medication used to treat mental illness) for Resident 8. This deficient practice increased the risk that psychotropic medications (affect brain activities associated with mental processes and behavior) used to manage behaviors would not be periodically reevaluated as intended. This increased the risk that Resident 8 may have experienced adverse effects related to psychotropic medications possibly leading to impairment or decline in her mental or physical condition, functional status, or psychosocial status. -Failing to develop a care plan with goal and interventions for administration of insulin (a medicine used to control the amount of sugar in the blood of patients with diabetes mellitus [DM-a disease that occurs when the sugar level is high in the blood]) for Resident 26. This deficient practice had the potential to lead to the inadequate care of Resident 26. Findings: a. A review of Resident 8's Admission Record indicated she was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including encephalopathy (a brain disorder that causes changes in brain function or structure possibly leading to the inability to reason and concentrate, memory loss, personality change, seizures, or twitching) A review of Resident 8's History and Physical dated 1/22/24, indicated she did not have the capacity to understand and make decisions. A review of Resident 8's Order Summary Report dated 5/31/24, indicated on 5/7/24, Resident 8 was prescribed risperidone three (3) milligrams (mg - a unit of measure for mass) by mouth two times a day for schizophrenia manifested by auditory and visual hallucinations seeing and hearing voices of people that are not there. A review of Resident 8's available care plans indicated there was no care plan to address Resident 8's problematic behavior of auditory and visual hallucinations seeing and hearing voices of people that are not there related to the use of risperidone. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/9/24 at 12:01 PM with the Director of Nursing (DON), the DON stated Resident 8's available care plans did not contain any care plan for auditory and visual hallucinations seeing and hearing voices of people that are not there for which risperidone was listed as a targeted intervention. The DON stated the facility failed to create a comprehensive care plan to address this problematic behavior. The DON stated the failure to care plan behaviors appropriately increased the risk that Resident 8 may receive risperidone or other psychotropic medications longer or at higher doses than necessary, possibly leading to a decline in her quality of life. b. A review of Resident 26's Admission Record (Face Sheet) indicated the facility admitted the resident on 2/9/2023, with diagnoses including unsteadiness on feet, major depressive disorder (a mental health condition that causes a low mood and a loss of interest in activities that once brought joy), and morbid obesity (a chronic disease characterized by an excess of body fat). A review of Resident 26's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 5/20/2024, indicated the resident's cognitive skills (ability to think, remember, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 26 required partial/moderate assistance with toileting hygiene, upper and lower body dressing, showering/ bathing, and personal hygiene. The MDS further indicated Resident 26 did not have diagnoses of diabetes and he was taking insulin. A review of the Physician's Orders dated 2/11/2024, indicated to administer regular insulin (a short-acting insulin that takes 30 minutes to one hour to start working, peaks in two to five hours, and lasts for up to 6 hours) subcutaneously (SQ- to inject under all the layers of the skin) as per sliding scale (varies the dose of insulin based on blood glucose level) if blood sugar is 150 - 199 milligrams per deciliter (mg/dl-unit of measurement [normal range for a diabetic according to American Diabetes Association: 80-130 mg/dl]) administer 4 units (a unit of measurement for insulin); if 200 - 249 mg/dl = 6 units; if 250 - 299 = 8 units; if 300 - 349 = 10 units; if 350 - 399 = 12 units; if 400 - 401 = 14 units, before meals and at bedtime for DM. The physician's order further indicated to notify the physician if blood sugar level was greater than 401 mg/dL. A review of Resident 26's Care Plans on 7/9/2024, indicated there was no individualized person-centered care plan for insulin administration including measurable objectives, monitoring, and a timetable to meet resident`s needs. During a concurrent interview and record review on 7/9/2024 at 1 PM, with Licensed Vocational Nurse (LVN) 2, Resident 26's face sheet, care plans, and physician's orders were reviewed. LVN 2 stated Resident 26 did not have a diagnosis of DM according to her face sheet. However, Resident 26 had an order to administer regular insulin per sliding scale. LVN 2 stated staff did not develop a care plan with goal and appropriate interventions for Resident 26's insulin use. LVN 2 stated licensed staff were required to develop a care plan with interventions to monitor Resident 26's insulin use. LVN 2 stated the potential outcome of not developing a care plan with person-centered interventions was lack of care and monitoring for the resident. During an interview on 7/11/2024 at 12:24 PM, the DON stated licensed staff were required to develop a care plan with appropriate interventions when a resident was taking insulin. The DON stated, licensed staff did not develop a care plan for Resident 26's insulin use and the potential outcome was lack of care, monitoring, and delivery of necessary services. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Behavioral Assessment, Intervention and Monitoring, revised March 2019, indicated the facility will provide, and residents will receive, behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan or care. The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree or severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly. A review of the facility`s policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, revised December 2016, indicated a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident`s physical, psychosocial, and functional needs is developed and implemented for each resident. The comprehensive person-centered care plan will include measurable objectives and timeframes, describe the services that are to be furnished to attain or maintain the resident`s highest practicable physical, mental, and psychosocial well-being. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident`s problem areas and their causes, and relevant clinical decision making. Assessments of the residents are ongoing and care plans are revised as information about the residents and the residents` conditions changed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on observation, interview, and record review, the facility failed to update and revise the care plan for two of three sampled resident's (Resident 12 and Resident 27). For Resident 27 after the resident sustained a fall on 5/31/2024 and Resident 12's hospice care plan (specialized care that provides physical comfort and emotional, social, and spiritual support for people nearing the end of life) did not reflect current physician's orders and had no been updated for over 10 months. This failure resulted in Resident 27 sustaining another fall on 7/2/2024 and had the potential to result in Resident 12 receiving inadequate care and services. Findings: a. A review of the face sheet indicated Resident 27 was readmitted to the facility on [DATE], with diagnoses that included anxiety, depression, and congestive heart failure (a condition when the heart does not pump enough blood in the body). A review of the Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 7/3/2024 indicated Resident 27 was cognitively intact (able to think, remember clearly to perform daily tasks) and needed supervision when ambulating. A review of the care plan dated on 5/11/2024, indicated Resident 27 was at risk for falls related to his current medical condition. The goal indicated the facility would minimize Resident 27's risk for fall and injuries daily for 3 months. The care plan interventions included having the resident's bed in lowest position, monitor resident's location through visual checks, keep in frequently monitored areas for closer staff monitoring, and encourage resident to use the call light. A review of the Change of Condition Evaluation form dated 5/31/2024 indicated Resident 27 had a fall (was found on the floor) at 5:15 PM. Resident 27 appeared to be weak and drowsier than usual and facility arranged for transportation to the hospital. A review of the resident's progress notes showed no updates to Resident 27's care plan for falls after Resident 27 had a fall on 5/31/2024. A review of the Change of Condition Evaluation form dated on 7/2/2024, indicated the CNA reported that they found Resident 27 on the floor at 10 PM, noted with a jerking episode. The Medical Doctor (MD) was notified and 911 was called. During a concurrent interview and review of Resident 27's care plans with the Licensed Vocational nurse (LVN 3) on 7/10/2024 at 9 AM, LVN 3 stated Resident 27's care plans were not updated and that a resident's care plan should be updated whenever a resident had a change of condition. LVN 3 stated the care plan should have been updated after Resident 27's fall on 5/31/2024. LVN 3 stated that if Resident 27's fall risk care plan was updated it could have potentially prevented Resident 27 from having another fall on 7/2/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the Director of Nursing (DON) on 7/10/2024 at 9:19 AM, the DON stated that a resident's care plan was updated during the IDT conference or when there was a change of condition. After review of Resident 27's care plan dated 5/11/2024, the DON stated Resident 27 was a high risk for fall and the fall risk care plan should have been updated after Resident 27's fall incident on 5/31/2024. b. A review of Resident 12's Admission Record indicated the facility readmitted the resident on 9/16/2023 with diagnoses that included dementia (loss of memory, thinking and reasoning), encounter for palliative care (specialized medical care for people living with a serious illness, such as cancer or heart failure), muscle wasting and atrophy (decrease in size and thinning of muscle tissue), and contracture of muscle (occurs when your muscles, tendons, joints, or other tissues tighten or shorten causing a deformity). A review of Resident 12's care plan revised 8/22/2023, indicated the resident was admitted to the facility under the care of Hospice 1 for the diagnosis of Alzheimer's (a progressive disease that destroys memory and other important mental functions). A review of Resident 12's MDS dated [DATE], indicated the resident had severely impaired cognitive skills for daily decision making (never/rarely made decisions) and required assistance with oral hygiene, toileting hygiene, upper body/lower body dressing, and personal hygiene. A review of the Physician's Orders dated 5/20/2024, indicated the resident was to be placed on hospice with Hospice 2. During a concurrent interview and record review on 7/10/2024 at 8:39 AM, Resident 12's hospice care plan was reviewed. LVN 1 stated Resident 12 was being seen by Hospice 2 and that the Hospice care plan interventions were last revised on 8/22/2023. LVN 2 stated the care plan was not revised to reflect Resident 12 was in fact being seen by Hospice 2 and the care plan should be resident specific. During a concurrent interview and record review on 7/10/2024 at 9:10 AM, Resident 12's hospice care plan was reviewed with the Director of Nursing (DON). The DON stated the care plan indicated Resident 12 remained with Hospice 1, but the care plan should have been revised to indicate the resident was being seen by Hospice 2. The DON stated the care plan's focus and interventions were last revised on 8/22/2023 and should be updated and resident specific. The DON further stated care plans should be reviewed and revised quarterly and as needed. The DON stated if a care plan was not revised to reflect the resident's current needs and orders there was potential the resident may not receive necessary care. The DON stated it would be an unnecessary care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised 12/2016 indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan will: include measurable objectives and timeframes; describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, ad psychosocial well-being, reflect currently recognized standards of practice for problem areas and conditions. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. The interdisciplinary team must review and update the care plan: when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 43851 Based on observation, interview, and record review, the facility failed to provide oral care to one of three sampled residents (Resident 12). Resident 12 had dry, cracked lips and did not receive oral care per the physician's order for 28 occurrences. This deficient practice had the potential for Resident 12 to develop a mouth infection and cause difficulty breathing. Findings: A review of Resident 12's Admission Record indicated the facility readmitted the resident on 9/16/2023 with diagnoses that included dementia (loss of thinking, remembering, and reasoning), encounter for palliative care (specialized medical care for people living with a serious illness, such as cancer or heart failure), muscle wasting and atrophy (decrease in size and thinning of muscle tissue), and contracture of muscle (occurs when your muscles, tendons, joints, or other tissues tighten or shorten causing a deformity). A review of Resident 12's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 4/16/2024, indicated the resident had severely impaired cognitive skills for daily decision making (never/rarely made decisions). The MDS indicated Resident 12 required assistance with oral hygiene, toileting hygiene, upper body/lower body dressing, and personal hygiene. A review of the Physician's Order dated 4/22/2024, indicated the resident was to be provided with oral care every two hours to prevent oral infection. A review of Resident 12's Treatment Administration Record (TAR) dated 6/1 -6/30/2024, indicated the resident was to receive oral care every two hours to prevent oral infection. The TAR further indicated there was no documentation to indicate oral care was provided for the following dates and times: -6/7/2024 at 2 AM, 4 AM, and 6 AM. -6/11/2024 at 12 AM, 2 AM, 4 AM, and 6 AM. -6/20/2024 at 6 AM. -6/21/2024 at 4 PM, 6 PM, 8 PM, 10 PM. -6/23/2024 at 6 AM. -6/24/2024 at 2 PM. -6/25/2024 at 6 AM. A review of Resident 12's TAR dated 7/1 -7/9/2024, indicated the resident was to receive oral care every two hours to prevent oral infection. The TAR further indicated there was no documentation to indicate oral care was provided for the following dates and times: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Maple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2625 Maple Ave. Los Angeles, CA 90011	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-7/1/2024 at 4 PM, 6 PM, 8 PM and 10 PM. -7/2/2024 at 4 PM, 6 PM, 8 PM and 10 PM. -7/5/2024 at 4 PM, 6 PM, 8 PM and 10 PM. -7/9/2024 at 6 AM. During a concurrent observation and interview on 7/8/2024 at 8:53 AM, in Resident 12's room, the resident was observed with their mouth open, dry cracked lips, and with a dry brown film of saliva at the back and top of the resident's mouth. Licensed Vocational Nurse (LVN) 1 observed Resident 12 and verified the observation. LVN 1 stated Resident 12 needed oral care and that oral care was supposed to be provided many times trough out the day for the resident. During a concurrent interview and record review on 7/10/2024 at 9:10 AM, Resident 12's physician's order for oral care, the TAR dated 6/1 - 6/30/2024, and TAR dated 7/1 - 7/9/2024 were reviewed with the DON. The DON stated there were gaps in Resident 12's TAR documentation and there was no way to verify Resident 12 received oral care because there was no documentation on the dates. The DON stated dry, cracked lips, and dry saliva were indicative that Resident 12 did not receive oral care and the was a potential for Resident 12 to develop an infection and difficulty breathing if they did not receive oral care. A review of the facility's policy and procedure titled, Mouth Care, reviewed 4/11/2024, indicated the purpose was to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent oral infection. Steps in the procedure indicated to gently turn the residents head towards you. Spread the towel under the resident's chin and across the pillow to protect the resident's clothing and/or bed covers. Position the emesis basin on the towel under the resident's chin. Gently open the resident's mouth. Hold the tongue in place with the tongue depressor. With your free hand, moisten the applicators with the mouthwash solution. Insert the applicator into the resident's mouth. Thoroughly wipe the roof of the resident's mouth, inside the cheeks, the tongue, and the teeth with the applicator. Rinse the resident's mouth by using fresh water on the applicators. Dry the resident's face and chin area. Remove the towel. Moisten the inside of the resident's mouth, tongue, and lips. Use a prepared swab or a water-soluble lubricant. The following information should be recorded in the resident's medical record. The date and time the mouth care was provided. The name and title of the individual (s) who provided the mouth care. All assessment data obtained concerning the resident's mouth. The certified nursing assistant should report to the licensed nurse to record in the medical record.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 50296 Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident 48) skin protective arm sleeve was applied. This failure resulted in Resident 48's left arm to swell and turn red. Findings: A review of Resident 48's History and Physical dated 6/4/2024, indicated the resident had a past medical history of dementia (loss of memory, thinking and reasoning), with psychotic features (a mental disorder characterized by a disconnect from reality), seizure disorder (excessive surge of electrical activity in the brain), and anxiety disorder (mental health disorder characterized with feelings of worry or fear that interferes with one's daily activities). Resident 48 had diffused cherry angiomas (harmless, pinhead like bumps on skin) on skin. A review the Resident 48's Order Summary Report dated 6/6/2024 indicated may use a Geri-Sleeves (a device that protects the arm from skin abrasions, bruises, snags, and tears) as tolerated for skin management. A review of Resident 48's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 6/9/2024, indicated Resident 48 required assistance with bathing, dressing, toileting, and eating. During an observation on 7/8/2024 at 9:27 AM in Resident 48's room, Resident 48 was resting in bed. There were two black colored scabs on his left upper arm. The square sticky dressing was hanging off Resident 48's first arm wound, and the sticky dressing was completely off from the second arm wound. During a concurrent observation and interview on 7/9/2024 at 9:34 AM with Treatment Nurse in Resident 48's room, Resident 48's left arm was red and swollen. Resident 48's dressing was taped around his left arm with swelling and redness in between the tape. The Treatment Nurse stated the dressing was taped too tight causing Resident 48's arm to swell. The Treatment Nurse stated the dressing should not be taped that tight, because it could cause poor circulation. During interview on 7/10/2024, the Director of Nursing (DON) stated the process for dressing changes was to follow the order and reevaluate the dressing applied for therapeutic or non-therapeutic response. The DON looked at the dressing taped around Resident 48's left arm and stated that it was not the correct way to apply a dressing. The DON stated if he was applying the dressing, he would apply a sleeve over the dressing, make sure tape was on skin, and not too tight. The DON stated the dressing should be assessed every shift, the charge nurse was supposed to review and look at dressing. The DON stated the resident was at risk for poor circulation of the arm, the dressing sticking to the skin wound, and infection due to the improper application of the skin dressing.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 43851 Based on observation, interview, and record review, the facility failed to maintain the correct Low Air Loss Mattress (LALM, a mattress designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) settings for one of three sampled residents (Resident 12). This deficient practice had the potential to lead to poor circulation (reduced blood flow to various body parts) and cause a pressure injury (localized skin and soft tissue injuries that form because of prolonged pressure and shear, usually exerted over bony prominence's) for Resident 12. Findings: A review of Resident 12's Admission Record indicated the facility readmitted the resident on 9/16/2023 with diagnoses that included dementia (loss of memory, thinking and reasoning), encounter for palliative care (specialized medical care for people living with a serious illness, such as cancer or heart failure), muscle wasting and atrophy (decrease in size and thinning of muscle tissue), and contracture of muscle (occurs when your muscles, tendons, joints, or other tissues tighten or shorten causing a deformity). A review of Resident 12's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 4/16/2024, indicated the resident had severely impaired cognitive skills for daily decision making (never/rarely made decisions) and required assistance with personal hygiene. The MDS indicated Resident 12 was dependent on help for rolling left and right in bed, was at risk for developing pressure ulcers and utilized a pressure reducing device for bed. The MDS further indicated Resident 12 did not have any pressure ulcers. A review of Resident 12's Care Plan revised 6/26/2024, indicated the resident was at risk for skin breakdown due to incontinence (loss of bladder control), Alzheimer's (a progressive disease that destroys memory and other important mental functions), aging process, and the risk for unavoidable decline due to hospice (specialized care that provides physical comfort and emotional, social, and spiritual support for people nearing the end of life). The care plan interventions indicated Resident 1 could have a LALM to prompt circulation and to monitor the LALM's functionality and setting every shift. A review of the Physician's Order dated 7/8/2024, indicated Resident 12 could have a LALM to promote blood circulation and profusion (the passage of fluid though the blood system) and to monitor the resident's LALM for proper functionality and setting. The physician's order indicated Resident 12's LALM was to have a setting of 118 pounds (lbs.) every shift. During a concurrent observation and interview on 7/8/2024 at 8:53 AM, in Resident 12's room, the resident's LALM was observed with Licensed Vocational Nurse (LVN) 1. The settings indicated 320 lbs. and LVN 1 stated Resident 12 was not 320 lbs. LVN 1 stated the LALM should be based on Resident 12's weight and stated Resident 12's LALM should be set to 118 lbs. LVN 1 stated Resident 12 had a LALM to prevent pressure ulcers, did not currently have any pressure ulcers but could potentially develop one with the LALM on the wrong setting. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/2024 at 9:10 AM, the Director of Nursing (DON) stated the LALM settings were based on the resident's weight, with physician's orders for the LALM settings to be at 118 lbs. The DON stated placing the LALM settings for Resident 12 at 320 lbs. was incorrect, which could cause the resident to not have proper circulation and result in resident injury. A review of the user manual titled, Med-Aire Assure 14530 8, Alternating Pressure & Low Air Loss Mattress System with Foam Base, dated 2014, indicated the pressure adjust knob was adjustable by patient's weight: Turn the Pressure Adjust Knob to set a comfortable pressure level by using the weight scale as a guide. The Operating Instructions indicated to turn the Pressure Adjust Knob to set a comfortable pressure level using the weight scale as a guide. A review of the facility's policy and procedure titled, Support Surface Guidelines, reviewed 4/11/2024, indicated redistributing support surfaces were to promote comfort for all beds - or chairbound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on interview and record review, the facility failed to ensure adequate supervision to prevent accidents for one of three sampled residents (Resident 27). Resident 27 did not receive frequent visual checks to monitor location, per the At Risk for Falls care plan. This failure resulted in the resident sustaining a fall on 5/31/24 and 7/2/24. Findings: A review of the face sheet indicated Resident 27 was readmitted to the facility on [DATE], with diagnoses that included anxiety, depression, and congestive heart failure (a condition when the heart does not pump enough blood in the body). A review of the Minimum Data Set (MDS, a standardized assessment and care-screening tool) indicated Resident 27 was cognitively intact and needed supervision when ambulating due to issues with generalized weakness and impaired gait and mobility (difficulty with moving). A review of the At Risk for Falls care plan dated on 5/11/2024, indicated the goal for Resident 27 was to minimize the resident's risk for fall and injuries daily for three months. The care plan interventions indicated to have bed in lowest position, monitor resident's location through visual checks, keep in frequently monitored areas for closer staff monitoring, and encourage resident to use the call light. A review of the fall risk assessment dated on 5/31/2024, indicated Resident 27 was at risk for falls. A review of the Change of Condition Evaluation form dated on 5/31/2024 and 7/2/2024, indicated Resident 27 had a fall on 5/31/2024 and 7/2/2024. A review of the resident's progress notes indicated that from 5/11 to 5/31/2024 and from 6/5/2024 to 7/2/2024, there were no visual checks of Resident 27 documented. During an interview with Licensed Vocational Nurse (LVN) 2 on 7/9/2024 at 10:50 AM, LVN 2 stated that Resident 27 was a high risk for falls and had tremors (uncontrollable shaking) which caused Resident 27 to have gait and mobility issues. LVN 2 stated that due to Resident 27's condition Resident 27 should have been checked more frequently which could have prevented Resident 27 from falling. LVN 2 stated that visual checks should be documented in the nurse's progress notes. During an interview with the Director of Nursing (DON) on 7/10/2024 at 9:19 AM, the DON stated that visual checks for resident's were ordered for those resident's that were at a high risk for falls. The DON stated that visual checks should be done every two hours to ensure the resident was safe. The DON stated that if a resident was not being closely monitored the resident had a higher chance of an accident occurring. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's revised policy dated March 2018 and titled, Falls and Fall Risk, Managing, indicated staff would monitor and document each resident's response to interventions intended to reduce falling or the risks for falling and if a resident continues to fall, staff would re-evaluate the situation and determine if it was appropriate to continue or change current interventions.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44309

Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 47) maintained acceptable parameters of nutritional status by failing to obtain accurate weight and perform a nutritional assessment. This deficient practice had the potential to result in increased weight loss for Resident 47.

Findings:

A review of Resident 47's Admission Record (Face Sheet) indicated the facility admitted the resident on 2/7/2024, with diagnoses including anxiety disorder (a condition with excessive worry and fear that interferes with daily activities), insomnia (a sleep disorder in which you have trouble falling and/or staying asleep), and dementia (loss of the ability to think, remember, and reason to levels that affect daily life and activities).

A review of Resident 47's Nutritional Assessment Form for admitted d 2/7/2024, indicated the resident's most recent weight was 209 Pounds (lbs.- a unit of weight) which was measured by a standing scale. The assessment form indicated Resident 47's goal weight range was 116-163 lbs. The assessment form further indicated Resident is very new to the facility, and she is very confused. She stated she has allergies but is not able to recall to what items. Resident's weight and height were obtained from her previous chart.

A review of Resident 47's physician History and Physical (H&P) dated 2/8/2024, indicated the resident was currently competent but had a history of intermittent (on and off) confusion which may impair (weaken) understanding.

A review of Resident 47's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 5/13/2024, indicated the resident's cognitive skills (ability to think, remember, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 47 was independent for eating and personal hygiene. The MDS further indicated Resident 47 had a weight loss of 5% or more in the last month or loss of 10% or more in the last six months and she was not on physician-prescribed weight loss regimen.

A review of Resident 47's Monthly Weight Record indicated the following:

7/3/2024 187.0 Lbs. Mechanical Lift (used to weigh non-ambulatory patients)

6/6/2024 190.0 Lbs. Mechanical Lift

5/2/2024 190.0 Lbs. Mechanical Lift

4/5/2024 191.0 Lbs. Mechanical Lift

3/6/2024 190.0 Lbs. Mechanical Lift

2/9/2024 198.0 Lbs. Mechanical Lift

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/7/2024 209.0 Lbs. Standing During a concurrent interview and record review on 7/9/2024 at 9:45 AM, with Licensed Vocational Nurse (LVN) 2, Resident 47's weights and nutritional assessments were reviewed. LVN 2 stated, Seems like Resident 47 lost weight since her admission to the facility. I did not report Resident 47's weight loss to the Registered Dietician (RD - a health professional with special training in diet and nutrition) or her physician. LVN 2 further stated, I do not see any nutritional assessments completed by RD for Resident 47 after the initial admission nutritional assessment dated [DATE]. over 5 months prior. During a concurrent interview and record review on 7/9/2024 at 3:29 PM, with the RD, Resident 47's weights and nutritional assessments were reviewed. The RD stated, On 2/7/2024, when I performed Resident 47's nutritional assessment upon admission, I did not obtain the resident's current weight and I used the weight indicated in her previous chart. I should have verified Resident 47's weight instead of using what they wrote in her previous chart. The RD stated Resident 47 was ambulatory and she was not using any ambulatory aids when she was walking. The RD stated, I do not know why staff used a mechanical lift to weigh Resident 47. Resident 47 was able to stand on the scale. The RD stated Resident 47 had weight loss since her admission, however, her weight loss was beneficial. The RD stated, I do not conduct quarterly nutritional assessments for all residents in the facility. My focus is the residents who lost weight or have nutritional issues. The RD stated that she did not perform any nutritional assessment for Resident 47 after her weight loss and that It was missed. The RD stated the potential outcome was lack of care and monitoring that could lead to further weight loss. During an interview on 7/11/2024 at 12:28 PM, the Director of Nursing (DON) stated staff were required to verify a resident's weight upon admission and to monitor his/her weight over time to identify weight loss/gain. The DON stated the RD was required to perform a thorough assessment for all residents upon admission, as needed. The DON stated the RD was required to conduct an assessment for residents who have lost weight and the RD did not perform any nutritional assessment for Resident 47 after she had lost weight. The DON stated even though the weight loss was beneficial for Resident 47, but an assessment was required. The DON stated the potential outcome was the inability to detect, care, and manage resident's increased weight loss. A review of the facility's policy and procedure titled, Nutritional Assessment, revised November 2017, indicated the dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission and as indicated by change in condition that places the resident at risk for impaired nutrition. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Weight Assessment and Interventions, revised September 2008, indicated the nursing staff would measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns were noted at this point, weights will be measured monthly thereafter. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight was verified, nursing will immediately notify the dietician in writing. Verbal notification must be confirmed in writing. The dietitian will respond within 24 hours of receipt of written confirmation. The dietitian will review the unit weight record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change have been met. Assessment information shell be analyzed by the multidisciplinary team and conclusions shall be made regarding the relationship between current medical condition or clinical situation and recent fluctuations in weight and whether and to what extend weight stabilization or improvement can be anticipated.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50296 Based on observation, interview, and record review, the facility failed to ensure residents receiving respiratory care was in accordance with the physician's order for one sampled resident (Resident 48). Resident 48's oxygen flow rate was not set to the physician ordered 2 liters. This failure had the potential to result in Resident 48 experiencing shortness of breath and lower oxygen saturation (the amount of oxygen carried by the red blood cells). Findings: A review of Resident 48's History and Physical dated 6/4/2024, indicated the resident had past medical history of chronic obstructive pulmonary disease (COPD - a lung disease that blocks airflow and make it difficult to breathe). A review the Resident 48's Order Summary Report, dated 6/3/2024, indicated, oxygen at 2 liters per minute via nasal cannula (thin, flexible tube that hooks around ears, with two prongs in the nose that delivers oxygen) continuously for diagnosis of COPD. A review of Resident 48's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 6/9/2024, indicated the resident required assistance with bathing, dressing toileting and eating. During a concurrent observation and interview on 7/9/2024 at 9:14 AM with Licensed Vocation Nurse (LVN) 1, in Resident 48's room, the oxygen flow rate was set at 1.5 liters per minute. LVN 1 stated the flow rate should be at 2 liters per minute due to Resident 48 having COPD. During interview on 7/10/2024 8:45 AM, the Director of Nursing (DON) stated if the order indicated 2 liters continuous then the setting should be 2 liters continuous. A review of the facility's policy and procedure titled, Oxygen Administration, dated 4/11/2024 indicated to verify that there was a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 49836 Based on interview and record review, the facility failed to ensure staff competency evaluations were completed for one of three sampled Certified Nursing Assistants (CNA) 1. This failure had the potential for a knowledge, training, and certification deficit which could lead to inadequate resident care. Findings: A review of CNA 1's employee file it indicated that CNA 1 was hired on 1/1/2023 and there was no competency evaluation completed. During a concurrent interview and record review on 7/11/2024 at 10:11 AM, the Director of Staff Development (DSD) stated the DSD was responsible for ensuring that newly hired employees completed their competency skills evaluation for their position. The DSD stated that completing a competency evaluation was important to determine if an employee was competent for the position. The DSD reviewed CNA 1's employee file and was unable to provide a competency skills evaluation for CNA 1. A review of the facility's revised policy and procedure dated April 11, 2024 and titled, Competency of Nursing Staff, indicated all nursing staff must meet the specific competency requirements defined by state law. In addition, licensed nurses and nursing assistants employed by the facility will participate in a facility-specific, competency-based staff development and training program, and demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40994 Based on observation, interview, and record review, the facility failed to accurately account for two doses of controlled medications (a high potential for abuse) affecting Residents 2 and 3 in one of two inspected medication carts (Medication Cart 1). This deficient practice increased the risk of diversion (any use other than that intended by the prescriber) of controlled mediations and that Residents 2 and 3 could have received too much or too little medication due to lack of documentation, possibly resulting in serious health complications requiring hospitalization . Findings: During an observation and concurrent interview of Medication Cart 1, on 8/27/24 at 11:21 AM, with the Director of Staff Development (DSD), the following discrepancies were found between the Controlled Drug Record (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) and the medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication): -Resident 2's Controlled Drug Record for clonazepam (Klonopin, a medication used to treat mental illness) 1 milligram (mg - a unit of measure for mass) indicated there were 12 doses remaining, however the medication card contained 11 doses. -Resident 3's Controlled Drug Record for tramadol (Ultram, a medication used to treat pain) 50 mg indicated there were 11 doses remaining, however the medication card contained ten doses. During a concurrent interview, the DSD stated she gave the missing controlled medications to Residents 2 and 3 earlier today, but failed to sign the Controlled Drug Record at the time of administration. The DSD stated it was policy to sign the used dose of the controlled medication on the Controlled Drug Record immediately after removing it from the bubble pack and that his helped keep track of controlled medication in order to reconcile them and prevented residents from receiving the medications more often than prescribed. The DSD stated if residents received controlled medications more often than prescribed, it may cause health complications requiring hospitalization . A review of the facility's policy titled, Controlled Medications, dated August 2014, indicated when a controlled medication was administered, the licensed nurse administering the medication immediately enters the signature of the nurse administering the dose on the accountability record at the time the medication was removed from supply.

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NAME OF PROVIDER OR SUPPLIER: Maple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2625 Maple Ave. Los Angeles, CA 90011	

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on interview and record review, the facility failed to ensure the physician responded to the consultant pharmacist's recommendation from 4/17/24 and 5/8/24, to justify the use of risperidone (a medication used to treat mental illness) in one of five sampled residents (Resident 8.) -Ensure the physician responded to the consultant pharmacist's recommendation from 3/18/24 to obtain an ammonia level (a lab value used to ensure certain medications are used safely) related to the use of divalproex sodium (anticonvulsant, a medication used to treat seizures) in one of five sampled residents (Resident 8.) -Ensure the physician responded to the consultant pharmacist's recommendation from 3/18/24, 4/17/24, and 5/8/24, to justify the use of quetiapine (Seroquel, a medication used to treat mental illness) in one of five sampled residents (Resident 35.) The deficient practice of failing to ensure the physician evaluated and responded to medication irregularities (potential issues with a resident's medication regimen) identified by the consultant pharmacist during the Medication Regimen Review (MRR - a monthly report from the consultant pharmacist identifying any medication irregularities in a resident's current medication regimen) increased the risk that Residents 8 and 35 could have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to their medication therapy possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Findings: a. A review of Resident 8's Admission Record indicated she was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including encephalopathy (a brain disorder that causes changes in brain function or structure possibly leading to the inability to reason and concentrate, memory loss, personality change, seizures, or twitching). A review of the History and Physical dated 1/22/24, indicated Resident 8 did not have the capacity to understand and make decisions. A review of the consultant pharmacist's recommendation, dated 3/18/24, indicated the consultant pharmacist asked the physician to consider monitoring Resident 8's blood ammonia levels related to the use of divalproex sodium. A review of the Minimum Data Set (MDS - a comprehensive resident assessment and care screening tool) dated 4/20/24, indicated Resident 8 was assessed as having neither seizure disorder nor schizophrenia as active diagnoses. A review of the consultant pharmacist's recommendations dated 4/17/24 and 5/8/24 indicated the consultant pharmacist asked the physician to reevaluate the use of risperidone in Resident 8 and ensure there was sufficient documentation and justification for its continued use. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 8's Order Summary Report indicated on 5/7/24 the resident was prescribed divalproex sodium 250 mg by mouth two times a day for seizure disorders related to other encephalopathy. A review of the Physician's Order Summary Report dated 5/31/24, indicated on 5/7/24, Resident 8 was prescribed risperidone three milligrams (mg - a unit of measure for mass) by mouth two times a day for schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves, may have grandiose delusions [strong beliefs of things that are untrue]) manifested by auditory and visual hallucinations seeing and hearing voices of people that are not there. A review of Resident 8's clinical record indicated there were no physician notes, psychiatric notes, admission records, or any other clinical record indicating Resident 8 had a diagnosis of schizophrenia or seizure disorder. A review of Resident 8's clinical record indicated there was no physician response to any of the consultant pharmacist's recommendations made above and no laboratory monitoring of blood ammonia levels had been ordered or conducted. b. A review of Resident 35's Admission Record indicated he was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including dementia (a group of conditions characterized by a decline in mental function including memory loss and judgement) and schizoaffective disorder (a mental illness characterized by hearing and seeing things that are not there, believing things that are not true, and mood swings.) A review of Resident 35's H&P, dated 5/9/24, indicated he was not competent to understand his medical condition. A review of Resident 35's Order Summary Report, dated 5/31/24, indicated on 5/7/24, Resident 35 was prescribed quetiapine (Seroquel, an antipsychotic medication used to treat mental illness) 37.5 milligrams (mg - a unit of measure for mass) three times a day related to schizoaffective disorder. Further review of Resident 35's physician orders indicated he had been using Seroquel regularly since his admission to the facility. A review of the consultant pharmacist's recommendations dated 3/18/24, 4/17/24, and 5/8/24 indicated the consultant pharmacist asked the physician to reevaluate the use of Seroquel in Resident 35 to ensure there was sufficient documentation and justification for its continued use. A review of Resident 35's clinical record indicated there was no physician response to the pharmacist's recommendation to reevaluate the use of quetiapine to ensure there was sufficient justification and documentation for its continued use. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/9/24 at 2:41 PM, the Director of Nursing (DON) stated the facility failed to respond to the consultant pharmacist's MRR request to provide documentation to support the use of risperidone for Resident 8 on 4/17/24 and 5/8/24. The DON stated the facility also failed to respond to the consultant pharmacist's recommendation to monitor the ammonia level related to Resident 8's divalproex sodium made on 3/18/24. The DON stated the failure to respond to the pharmacist's requests for clinical justification on risperidone increased the risk that Resident 8 may receive antipsychotic medication longer or at higher doses than necessary possibly leading to a decline in quality of life. The DON stated the failure to respond to the pharmacist's request to monitor lab work increased the risk that the resident may experience toxicity from divalproex sodium, possibly leading to medical complication requiring hospitalization . During an interview on 7/10/24 at 10 AM, the DON stated the facility failed to respond to the consultant pharmacist's requests to provide a clinical justification to use Seroquel on 3/18/24, 4/17/24, and 5/8/24 for Resident 35. The DON stated because Resident 35 had dementia, the use of antipsychotic medication increased the risk of early death. The DON stated usually the physician would provide a written clinical justification explaining why the benefits outweigh the risks of continuing this medication, but the facility failed to follow up on the recommendation or receive any response back from the physician. The DON stated failing to respond to the pharmacist's recommendations increased the risk that Resident 35 may receive antipsychotic medications for longer or at higher doses than was necessary leading to a decline in his quality of life. A review of the facility's policy titled, Medication Regimen Review (monthly report), dated June 2021, indicated the consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly. The MRR included evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functions and prevents or minimizes adverse consequences related to medication therapy. Recommendations are acted upon and documented by the facility staff and/or the prescriber. The physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing by the next physician visit.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on interview and record review, the facility failed to provide sufficient documentation to support a diagnosis of seizure disorder in one of five residents sampled for unnecessary medications (Resident 8.) -Monitor valproic acid levels (a laboratory test used to ensure medications used to treat seizures are present at a safe and effect level in the blood) related to the use of divalproex sodium (a medication used to treat seizures) in one of five residents sampled for unnecessary medications (Resident 8.) The deficient practices of failing to sufficiently document a diagnosis of seizure disorder and monitor valproic acid levels related to the use of divalproex increased the risk that Resident 8 could have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) or seizures related to valproic acid levels being too high or too low leading to medical complications possibly resulting in hospitalization . Findings: A review of Resident 8's Admission Record dated 7/9/24, indicated she was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including encephalopathy (a brain disorder that causes changes in brain function or structure possibly leading to the inability to reason and concentrate, memory loss, personality change, seizures, or twitching). A review of Resident 8's History and Physical dated 1/22/24, indicated she did not have the capacity to understand and make decisions. A review of the Order Summary Report indicated on 5/7/24, Resident 8 was prescribed divalproex sodium 250 milligrams (mg - a unit of measure for mass) by mouth two times a day for seizure disorders related to other encephalopathy. Further review of Resident 8's Order Summary Report indicated there were no orders to perform routine monitoring of valproic acid levels. A review of Resident 8's care plan for seizure disorder, dated 4/21/24, indicated to monitor labs and report any subtherapeutic or toxic results to MD (Depakote [brand of divalproex] level). A review of Resident 8's Minimum Data Set (MDS - a comprehensive resident assessment tool) assessment Section I (active diagnoses), dated 4/20/24, indicated she did not have a diagnosis of seizure disorder. A review of Resident 8's clinical record indicated there were no physician notes, neurologist notes, admission records, or any other clinical record indicating Resident 8 had a diagnosis of seizure disorder or any record that Resident 8 had a seizure in the facility or was ever hospitalized for a seizure. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/9/24 at 12:01 PM, the Director of Nursing (DON) stated the facility failed to document any evidence that Resident 8 had seizure disorder in the clinical record. The DON stated divalproex sodium was previously used for behavioral management due to the resident seeking exits and was converted to seizure disorder in April of 2024. The DON stated the facility did not order a laboratory draw to check the valproic acid level at that time to determine whether it was at an effective level in her blood. The DON stated the resident was at high risk for seizures due to her encephalopathy but had never had a documented seizure since her admission to the facility. The DON stated the MDS Quarterly assessment dated [DATE] Section I did not contain a diagnosis of seizure disorder. The DON stated the facility only measured the valproic acid level once upon admission in January 2024 and the result was at a level too low to be effective to control seizure disorder. The DON stated the facility did not recheck the valproic acid level at any later date or once its indication was changed to seizure disorder. The DON stated that failure to provide adequate documentation regarding this resident seizure disorder or monitor lab work necessary to ensure medication's safety and effectiveness increased the risk that Resident 8 could have seizures or toxicity from adverse effects of the medication possibly leading to medical complications requiring hospitalization . A review of the facility's policy titled, Medication and Treatment Orders, revised July 2016, indicated orders for medications will be consistent with principles or safe and effective order writing. A review of the facility's policy titled, Seizures and Epilepsy - Clinical Protocol, revised November 2018, indicated the physician will monitor antiepileptic medication blood levels periodically, where applicable, for individuals who have been seizure free for an extended time, the physician will periodically consider tapering antiepileptic medications. The physician will document clinically valid reasons for maintaining a current dose without attempting any reduction.

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F 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40994

Based on interview and record review, the facility failed to provide sufficient documentation to support a diagnosis of schizophrenia (a mental illness characterized by seeing or hearing things that are not there) related to the use of risperidone (a medication used to treat mental illness) in one of five residents sampled for unnecessary medications (Resident 8.)

The deficient practice of failing to ensure risperidone was only used to treat a medical condition as diagnosed and documented in the medical record increased the risk that Resident 8 could have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to her medication therapy possibly leading to impairment or decline in her mental or physical condition or functional or psychosocial status.

Findings:

A review of Resident 8's Admission Record indicated she was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including encephalopathy (a brain disorder that causes changes in brain function or structure possibly leading to the inability to reason and concentrate, memory loss, personality change, seizures, or twitching).

A review of Resident 8's History and Physical dated 1/22/24, indicated she did not have the capacity to understand and make decisions.

A review of Resident 8's Order Summary Report indicated on 5/7/24, Resident 8 was prescribed risperidone three (3) milligrams (mg - a unit of measure for mass) by mouth two times a day for schizophrenia manifested by auditory and visual hallucinations seeing and hearing voices of people that are not there.

A review of Resident 8's minimum data set (MDS - a comprehensive resident assessment and care screening tool) dated 4/20/24, indicated she was assessed as not having schizophrenia as active diagnoses.

A review of Resident 8's available care plans indicated there was no care plan to address Resident 8's problematic behavior of auditory and visual hallucinations seeing and hearing voices of people that are not there related to the use of risperidone.

A review of Resident 8's clinical record indicated there were no physician notes, psychiatric notes, admission records, or any other clinical record indicating Resident 8 had a diagnosis of schizophrenia.

A review of the consultant pharmacist's recommendations dated 4/17/24 and 5/8/24 indicated the consultant pharmacist asked the physician to reevaluate the use of risperidone in Resident 8 and ensure there was sufficient documentation and justification for its continued use.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 8's clinical record indicated there was no physician response to any of the consultant pharmacist's recommendations made above to ensure there was adequate documentation and justification for the continued use of risperidone. During an interview on 7/9/24 at 12:01 PM, the Director of Nursing (DON) stated he was unable to provide any clinical evidence to support Resident 8's diagnosis of schizophrenia. The DON stated there was no psychiatric note or any other physician note indicating this resident had a diagnosis of schizophrenia present in her clinical record. The DON stated this diagnosis may have been made before the resident's admission to the facility but stated he could not demonstrate the diagnosis was present on any of her admission paperwork. The DON stated there was no evidence this diagnosis was evaluated by any of her present medical team since admission to this facility. The DON stated although Resident 8's order for Risperdal was listed as being used for schizophrenia, the MDS Quarterly assessment completed 4/20/24 did not contain a diagnosis of schizophrenia in Section I. The DON stated Resident 8's available care plans did not contain any care plan for auditory and visual hallucinations seeing and hearing voices of people that are not there for which risperidone was listed as a targeted intervention. The DON stated the failure to document diagnoses adequately, care plan behaviors appropriately, or respond to the pharmacist's requests for clinical justification on risperidone increased the risk that she may receive antipsychotic medication longer or at higher doses than necessary possibly leading to a decline in quality of life. A review of the facility's policy titled, Antipsychotic Medication Use, dated October 2017, indicated an antipsychotic medication should be used only for conditions/diagnoses as documented in the record and as meet the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Training Revision (DSM-IV TR) or subsequent editions.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Four medication errors out of 26 total opportunities contributed to an overall medication error rate of 15.38 % affecting three of five residents observed for medication administration (Residents 19, 35, and 45.) The medication errors noted were as follows: -Administration of clonazepam (Klonopin, a controlled substance medication, sedative, used to treat mental illness) to Resident 45 without a Physician's Order. -Allowed Resident 19 to self-administer fluticasone nasal spray (Flovent, a medication used to treat allergies) without prior approval. -Administration of Vitamin C (a supplement) to Resident 35 without a Physician's Order -Omitted one dose of Calcium/Vitamin D (a supplement) to Resident 35 The deficient practice of failing to administer medications in accordance with the physician's orders, including any required time frame, increased the risk that Residents 19, 35, and 45 may have experienced medical complications possibly resulting in hospitalization . Findings: During an observation on 7/9/2024 at 8:21 AM, Resident 45 was observed taking the following medication prepared by Licensed Vocational Nurse (LVN) 1: -One tablet of Kloniopin 0.5 milligrams (mg - a unit of measure for mass). A concurrent observation of the pharmacy label indicated Resident 45's Klonopin was filled on 7/4/2024. During an observation on 7/9/2024 at 8:40 AM, Resident 19 was observed self-administering Flonase nasal spray medication prepared by LVN 2. During an observation on 7/9/2024 at 8:49 AM, LVN 2 was observed preparing the following medications for Resident 35: -One tablet of aspirin (a medication used to prevent blood clots) 81 mg chewable -One tablet of finasteride (a medication used to treat prostate problems) 5 mg -One and one-half tablets of quetiapine (a medication used to treat mental illness) 25 mg -One tablet of Eliquis (a medication used to prevent blood clots) 5 mg -Two tablets of Vitamin C 250 mg. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/9/2024 at 8:54 AM, Resident 35 was observed taking all the medications above by mouth with juice. A review of Resident 45's Admission Record indicated she was admitted to the facility on [DATE] with diagnoses including anxiety disorder (a mental health disorder characterized by feeling or worry or fear that are strong enough to interfere with daily activities). A review of Resident 45's History and Physical dated 1/11/2024, indicated she was competent to understand her medical condition. A review of Resident 45's available physician's orders indicated there was no current order in Resident 45's clinical record for Klonopin 0.5 mg between 7/4 and 7/9/2024. A review of Resident 45's Medication Administration Record for July 2024 indicated there was no recorded doses of Klonopin or ability to record doses of Klonopin between 7/4 and 7/9/2024. A review of Resident 19's Admission Record indicated he was admitted to the facility on [DATE] with diagnoses including anxiety disorder. A review of Resident 19's H&P, dated 5/9/2024, indicated he was not competent to understand his medical condition. A review of Resident 19's Order Summary Report, dated 5/31/2024, indicated he was prescribed Flonase nasal spray to administer one spray in each nostril one time a day for allergic rhinitis (allergies) to be clinician administered. A review of Resident 19's Self-Administration of Medication Evaluation, dated 5/26/2023, indicated Resident 19 did Not wish to self-administer medications. A review of Resident 19's clinical record indicated there was no documentation from an interdisciplinary team (IDT - a multi-discipline group of healthcare professionals involved in periodically meeting and planning care for individual residents) or physician's order indicating it was safe for Resident 19 to administer his own medications. A review of Resident 35's Admission Record indicated he was readmitted to the facility on [DATE] with diagnoses including dementia (a group of conditions characterized by a decline in mental function including memory loss and judgement) and schizoaffective disorder (a mental illness characterized by hearing and seeing things that are not there, believing things that are not true, and mood swings). A review of Resident 35s H&P, dated 5/9/2024, indicated he was not competent to understand his medical condition. A review of Resident 35's Order Summary Report, dated 5/31/2024, indicated he did not have an active physician's order for Vitamin C. Further review of the Order Summary Report indicated he was to receive one tablet of Calcium/Vitamin D 500 mg/200 International Unit (IU - a unit of dosage for Vitamin D) during the 9 AM medication pass. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/9/2024 at 9:52 AM, LVN 2 stated she accidentally administered Vitamin C to Resident 35 this morning instead of Calcium/Vitamin D 500/200. LVN 2 stated she was confused and accidentally administered the wrong medication. LVN 2 stated administering the wrong mediation to a resident could result in serious medical complications possibly resulting to hospitalization or death. LVN 2 stated she allowed Resident 19 to administer his own Flonase nasal spray this morning because it was his preference. LVN 2 stated there was no prior approval or physician's order for Resident 19 to self-administer Flonase. LVN 2 stated Resident 19's Flonase was supposed to be clinician administered rather than self-administered. LVN 2 stated when an order was listed for clinician administered for any medication requiring any form of technique, she would be required to don gloves, instruct the resident on how to prepare, and administer the dose personally to the resident. LVN 2 stated allowing residents to self-administer without any sort of evaluation for safety, increased the risk that they may administer the wrong dose of the medication due to poor technique, possibly resulting in medical complications. During an interview on 7/9/2024 at 9:58 AM, LVN 1 stated he administered Klonopin for Resident 45 this morning despite having no record of a physician's order in the resident's clinical record. LVN 1 stated he administered it because the pharmacy filled it recently on 7/4/2024. The medication was available in the cart, and the MAR indicated orders to monitor for adverse effects and behaviors related to its use. LVN 1 stated he failed to see that there was no way to record the administration of the Klonopin in the MAR since there was currently no record of an active physician's order. LVN 1 stated he should have held the medication and clarified whether there was an active physician's order for Resident 45's Klonopin prior to administering the medication. LVN 1 stated administering medications without an order or without a record of when it was given increased the risk that Resident 45 could have experienced medical complications long-term possibly resulting in hospitalization . A review of the facility's policy titled, Administering Medications, revised April 2019, indicated medications were administered in a safe and timely manner, and as prescribed. Medications were administered in accordance with prescriber orders, including any time frame. The individual administering the medication checks the label THREE (3) times to verify, the right medication, before giving the medication. The individual administering the medication initials on the resident's MAR on the appropriate line after giving each medication and before administering the next ones. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, have determined that they have the decision-making capacity to do so safely. A review of the facility's policy titled, Documentation of Medication Administration, last revised April 2007, indicated the facility shall maintain a medication administration record to document all medications administered, a nurse shall document all medication administered to each resident on the resident's medication administration record (MAR.) Administration of medication must be documented immediately after (never before) it is given. A review of the facility's policy titled, Self-Administration of Medications, last revised February 2021, indicated residents have the right to self-administer medication if the interdisciplinary team determined that it was clinically appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment, the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medication was safe and clinically appropriate for the resident. If it was deemed safe and appropriate for a resident to self-administer medication, this was documented in the medical record and care plan.

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 07/11/2024
NAME OF PROVIDER OR SUPPLIER: Maple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2625 Maple Ave. Los Angeles, CA 90011	

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40994 Based on observation, interview, and record review the facility failed to: -Discard and replace two expired insulin (a medication used to treat high blood sugar) pens affecting Residents 38 and 43 in one of two inspected medication carts (Medication Cart 2.) -Label one open bottle of latanoprost (a medication used to treat eye problems) with an open date affecting Resident 33 in one of two inspected medication carts (Medication Cart 1.) -Ensure an opened insulin (a medication is used to control high blood sugar) was not stored in the refrigerator per the manufacturer's requirements for Resident 26. The deficient practices of failing to label medications per the manufacturers' requirements and remove expired medications from the medication carts increased the risk that Residents 33, 38, and 43 could have received medication that had become ineffective or toxic due to improper storage possibly leading to health complications resulting in hospitalization or death. The deficient practice of ensuring an opened insulin was not stored in the refrigerator had the potential for Resident 26 to experience an uncomfortable burning and stinging sensation (a sudden burning pain) at insulin injection site. Findings: 1. During an observation on 7/9/24 at 10:53 AM of Medication Cart 2 with the licensed vocational nurse (LVN 1), the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: a. One opened insulin lispro (a type of insulin) pen for Resident 38 was found labeled with an open date of 6/1/23. According to the manufacturer's product labeling, open insulin lispro pens should be used or discarded with 28 days after opening. b. One opened Lantus Solostar (a type of insulin) pen for Resident 43 was found labeled with an open date of 6/3/24. According to the manufacturer's product labeling, open Lantus Solostar pens should be used or discarded with 28 days after opening. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/9/24 11:05 AM with LVN 1, LVN 1 stated Resident 38's lispro and Resident 43's Lantus Solostar pens are expired and should have been removed from the cart and replaced as they have been open for longer than 28 days. LVN 1 stated if expired insulin is not removed from the carts there is a risk that it could be administered to the resident resulting in poor blood sugar control. LVN 1 stated if a resident has poor blood sugar control, over time it may lead to medical complications requiring hospitalization . 2. During a concurrent observation and interview on 7/9/24 at 11:12 AM of Medication Cart 1 with LVN 2, the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: a. One opened bottle of latanoprost eye drops were found stored at room temperature not labeled with an open date. According to the manufacturer's product labeling, once stored at room temperature, latanoprost eye drops must be used or discarded within 6 weeks. LVN 2 stated the latanoprost for Resident 33 was opened and stored at room temperature but does not have an open date. LVN 2 stated it needs to be dated once it is open and stored at room temperature because it expires 42 days later. LVN 2 stated not labeling the open latanoprost with an open date increases the likelihood that Resident 33 may receive the latanoprost once its expired possibly leading to a worsening of his glaucoma or other medical complications. 3. A review of Resident 26's Admission Record (Face Sheet) indicated the facility admitted the resident on 2/9/2023, with diagnoses including unsteadiness on feet (a pattern of walking that is unstable), major depressive disorder (a mental health condition that causes a low mood and a loss of interest in activities that once brought joy), and morbid obesity (a chronic disease characterized by an excess of body fat). A review of Resident 26's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 5/20/2024, indicated the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 26 required partial/moderate assistance (the helper does less than half the effort) with toileting hygiene, upper and lower body dressing, showering/ bathing, and personal hygiene. The MDS further indicated that Resident 26 did not have diagnoses of diabetes (a disease that occurs when the sugar level is high in the blood), and he was taking insulin. A review of Resident 26's Physician's Orders dated 2/11/2024, indicated to administer regular insulin (a short-acting insulin that takes 30 minutes to one hour to start working, peaks in two to five hours, and lasts for up to 6 hours) subcutaneously (SQ- to inject under all the layers of the skin) as per sliding scale (varies the dose of insulin based on blood glucose level) if blood sugar is 150 - 199 milligrams per deciliter (mg/dl-unit of measurement [normal range for a diabetic according to American Diabetes Association: 80-130 mg/dl]) administer 4 units of insulin (a unit of measurement for insulin); if 200 - 249 = 6 units; if 250 - 299 = 8 units; if 300 - 349 = 10 units; if 350 - 399 = 12 units; if 400 - 401 = 14 units, before meals and at bedtime for DM. The physician order further indicated to notify the physician if blood sugar level is greater than 401 mg/dL. (continued on next page)

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	055036	A. Building B. Wing	07/11/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 26's Medication Administration Record (MAR) for July 2024, indicated that the resident received 4 units of regular insulin on 7/8/2024 at 9 PM. During a concurrent observation and interview on 7/9/2024 at 2:09 PM, with Licensed Vocational Nurse 2 (LVN 2), Resident 26's insulin bottle labeled with open date of 7/8/2024, and it was place inside the refrigerator. LVN 2 stated insulin bottles were not required to be stored in the refrigerator after being opened. LVN 2 stated I do not know why staff placed the opened insulin bottle in the fridge. LVN 2 stated the potential outcome of injecting a resident cold insulin was a burning sensation and discomfort. A review of the facility's policy titled, Storage of Medications, dated August 2019, indicated medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations of those of the supplier. Outdated, contaminated, or deteriorated medications are immediately removed from stock, disposed of according to procedures for medication disposal. A review of facility's policy and procedure titled, Storage of Medication, revised November 2020, indicated the facility stores all drugs and biologicals in safe, secure, and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity control. A review of National Library of Medicine (NLM)'s Insulin and Syringes - Storage and Safety, section reviewed 8/12/2022, indicated to store opened insulin bottles or reservoirs or pens at a room temperature of 59 degrees Fahrenheit (59 F- temperature scale) to 86 F. You can store most opened insulin at room temperature for a maximum of 28 days.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 47441 Based on observations, interviews, and record review, the facility failed to ensure kitchen staff were routinely trained and evaluated for competency skills as followed: a. Staff failed to verbalize when to perform hand hygiene, when going from dirty to clean area. b. Staff failed to verbalize proper dishwashing for air drying. c. Staff failed to verbalize how to check dish machine temperatures. d. Staff failed to verbalize and follow the manufacturer's guidelines of chlorine test paper (a type of test strip) when checking the chlorine (a chemical used to disinfect dishes) sanitizer concentration. e. Staff failed to demonstrate how to properly check Quaternary ammonium (QUAT, a chemical used to sanitize kitchen surfaces) sanitizer concentration based on manufacturer's instruction. These failures had a potential to result in cross-contamination (a transfer of bacteria from one object to another), unsanitized dishware and bacterial growth to food that could lead to food borne illness (an illness caused by contaminated food and beverages) in 44 of 45 medically compromised residents who received food and ice from the kitchen. Findings: a. During an observation of the dishwashing process on 7/9/2024 at 8:25 AM, Dietary Aide 1 (DA 1) touched the cleaned dishes then put away the clean dishes without washing hands or changing gloves. During a concurrent observation of DA 1 dishwashing and interview with Dietary Supervisor (DS) on 7/9/2024 at 8:30 AM, the DS stated staff could not change their gloves each time they go from dirty to clean as this was her first-time hearing that. The DS stated she was not sure if this practice was acceptable and needed to ask her counselor. During an interview with the Infection Prevention Nurse (IPN) on 7/9/2024 at 9:21 AM, the IPN stated staff should perform handwashing or hand hygiene when touching dirty items before handling clean items. The IPN stated anything that would contaminate the hands with microscopic (anything that could not be seen with the naked eye) bacteria could cause vomiting and diarrhea to the residents. A review of the facility's policy and procedure (P&P) titled, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, dated 4/11/2024, indicated Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. (6) Employees must wash their hands: (f) After handling soiled equipment or utensils; (h) after engaging in other activities that contaminate the hands. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Dishwashing Machine Use, dated 7/9/2024 indicated The following guidelines will be followed when dishwashing: (a) wash hands before and after running dishwashing machine, and frequently during the process. A review of the facility's job description titled, Dietary Supervisor, signed by the DS, dated 9/6/2023, indicated the DS essential duties and responsibilities included to ensure that safe food handling techniques are used. A review of the facility's competency checklist titled, Competency, signed by the DS and Registered Dietitian 1 (RD 1) on 7/9/2024, indicated the DS had met competency and had thorough knowledge of managing personnel to ensure compliance with safety and sanitation regulations. b. During an observation of the dishwashing process by DA 1 and the DS on 7/9/2024 at 8:47 AM, DA 1 and DS did not air dry the plates and trays and stacked the trays and plates wet. During concurrent observation of dishwashing process and interview with DS on 7/9/2024 at 8:58 AM, the DS stated the last step of dishwashing was air drying and they were not allowed to wipe the dishes with a towel. The DS stated the cups were stacked wet and it was an okay practice because it needed to be air dried. The DS stated the cups should be dried one at a time and it was okay to stack them wet. The DS stated DA 1 was trained by the staff that had three years of experience. A review of the facility's P&P titled, Dishwashing Machine Use, dated 7/9/2024 indicated Food staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation. A review of the facility's P&P titled, Sanitation, dated 7/9/2024 indicated (10) Food preparation equipment and utensils that are manually washed will be allowed to air dry whenever practical. A review of the facility's job description titled, Dietary Aide, signed by DA 1, dated 1/16/2024, indicated that DA 1 essential duties and responsibilities included ensuring that a good standard of hygiene and cleanliness was maintained throughout the kitchen to meet the required standard of practice prescribed by environmental health agencies. A review of the facility's competency checklist titled, Food and Nutrition: Competency Checklist - Food Service Worker, signed by DA 1 and Registered RD 1, indicated DA 1 met competency in demonstrating correct sanitation of equipment, utensils, and surfaces. c. During concurrent observation of the dishwashing process and interview with DA 1 on 7/9/2024 at 9:11 AM, DA 1 stated he scraped the trash from the soiled dishes, placed the dishes in dishmachine and checked the machine temperature in the morning. DA 1 stated the dishmachine temperature had to be 110 degrees Fahrenheit (F, a scale of temperature) to 120 F. DA 1 retrieved the chlorine test strips, pulled a strip and ran the machine. DA 1 lifted the dishmachine door after five seconds then dipped the chlorine test strip. DA 1 stated the test strip turned purple and it indicated 120 F. During concurrent observation of the dishwashing process and interview with Dietary Aide 4 on 7/9/2024 at 11 AM, DA 4 stated he helped with dishwashing but needing to ask as how to check the temperature of the dishmachine. DA 4 stated he had not done a whole lot of the washing, but he knew the temperature was at 120 F. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Dishwashing Machine Use, dated 7/9/2024, indicated (7) The operator will check temperature using the machine gauge with each dishwashing machine cycle and will record the results in a facility approved log. The operator will monitor gauge frequently during dishwashing machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately. A review of the facility's P&P titled, Sanitation, dated 7/9/2024, indicated Dishwashing machines must be operated using the following specifications: Low temperature dishwasher (chemical sanitation) (a) wash temperature (120 F). A review of the facility's job description titled, Dietary Aide, signed by DA 4, dated 5/25/2024, indicated that DA 4 essential duties and responsibilities included ensuring that a good standard of hygiene and cleanliness was maintained throughout the kitchen to meet the required standard of practice prescribed by environmental health agencies. A review of the facility's competency checklist titled, Food and Nutrition: Competency Checklist - Food Service Worker, signed by DA 4 and RD 1, indicated DA 4 had no competency verification in operating dishmachine. d. During a concurrent demonstration of the dishmachine chlorine concentration testing and interview with DA 4 on 7/9/2024 at 11 AM, DA 4 dipped the chlorine test strips and compared it to the color chart and stated 50 parts per million ([ppm] measure of concentration) was not a good concentration. During a concurrent demonstration of the dishmachine chlorine concentration testing and interview with Dietary Aide 3 (DA 3) on 7/9/2024 at 11 AM, DA 3 stated it was the second cycle of the dishmachine when she checked the chlorine concentration in the dishmachine. DA 3 dipped and shook the chlorine test strip for four seconds then compared it to the color chart. DA 3 stated it was important to follow manufacturer's guidelines to make sure the chlorine was in the right concentration and that it was cleaning the dishes. DA 3 stated if the chlorine was not in the right concentration, it would not clean the dishes and could get the residents sick such as stomach flu. During concurrent review of the chlorine test paper and interview with DA 3 on 7/9/2024 at 11:35 AM, chlorine test strip manufacturer's guidelines indicated Lot 101221 Expiration date 2/2024. Dip one test strip into solution without agitation. Blot dry. Compare immediately to color chart. DA 3 stated she did not follow the chlorine manufacturer's guidelines. During an interview on 7/9/2024 at 11:26 AM, the DS stated it was important to follow the chlorine test strips manufacturer's guidelines to ensure the chlorine concentration was accurate to sanitize dishes. The DS stated potential outcome to the residents would be they could get sick of fever because of germs in the dishes. A review of facility's P&P titled, Dishwashing Machine Use, dated 7/9/2024, indicated Dishwashing machine chemical sanitizer concentrations and contact times will be as follows: chlorine 50-100 ppm with 10 seconds contact time. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's job description titled, Dietary Aide signed by DA 3, dated 6/13/2023, indicated that DA 3 essential duties and responsibilities included ensuring that a good standard of hygiene and cleanliness was maintained throughout the kitchen to meet the required standard of practice prescribed by environmental health agencies. A review of the facility's competency checklist titled, Food and Nutrition: Competency Checklist - Food Service Worker, signed by DA 3 and RD 1, indicated DA 3 met competency in using proper sanitizer solution range, sanitizing strip log. e. During a concurrent demonstration of the red bucket sanitizing process and interview with DA 3 on 7/9/2024 at 11:20 AM, DA 3 stated red bucket was for sanitizer, and they used Hydrion test paper to check the proper concentration of the sanitizing solution. DA 3 stated they used hot water when testing the solution. Testing solution temperature was at 111 F. During concurrent review of the Quat sanitizer test strip manufacturer's guidelines and interview with DS on 7/9/2024 at 11:34 AM, Hydrion T-10 test strip indicated Lot 201122 Expiration date 1/1/2024, Instructions: (1) Dip paper in quat solution, not foam surface, for 10 seconds. Do not shake. Compare colors at once. (2) Testing solution should be between 65-75 . (3) Testing solution should have a neutral pH. (4) Follow manufacturer's dilution instructions carefully. The DS stated they do not monitor temperature for testing solution. The DS stated it was important to follow test strip manufacturer's guidelines to ensure the sanitizer was in the accurate concentration to clean and sanitize kitchen surfaces. A review of facility's P&P titled, Dishwashing Machine, dated 7/9/2024, indicated Quaternary ammonium (QAC) based sanitizers are often preferred over chlorine and iodine sanitizers due to its longer lifespan, non-corrosive nature and overall safeness. It's a lot less caustic than chlorine and can handle a lot more soiling than the other options. Testing your QUAT sanitizer is still just as important though as Quaternary ammonium does not function well in hard water. Concentration required 150-200 ppm. Water temperature required 75 F. A review of Food Code 2017 indicated 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitation- Temperature, pH, Concentration, and Hardness. Verifying the adequacy of chlorine-based solutions can be accomplished on an on-going basis by confirming that the concentration, temperature, and pH of the sanitizing solutions comply with paragraphs 4-501.114 (A) using acceptable test methods and equipment. The manufacturer should provide methods (e.g. test strips, kits, etc.) to verify that the equipment consistently generates solution on-site at the necessary concentration to achieve sanitation.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47441 Based on observation, interview, and record review, the facility failed to follow the facility menu when residents on a regular diet consistency (diets with no restriction) had no gravy on their trays. This deficient practice had the potential to cause a decrease in food intake resulting to unintentional (not done on purpose) weight loss to 39 of 45 residents. Findings: A review of the facility's menu spreadsheet (a list containing types and amount of foods of what each diet type would receive) titled Daily Spreadsheet dated 7/8/2024, Monday, indicated residents on the following diets would receive gravy: -Regular diet one ounce ([1 oz] a unit of measurement) -No added salt diet ([NAS], no salt packets on the trays) 1 oz -Regular diet, large portion 2 oz -Regular diet, small portion 1 oz -Consistent Carbohydrate (diet that contained same servings of carbohydrate per meal to control blood glucose level), NAS 1 oz. During an observation of the trayline (an area where resident's foods were assembled) on 7/8/2024 at 12:06 PM, regular consistency diet trays had no gravy. During concurrent observation of a regular diet test tray and interview with the Dietary Supervisor (DS) on 7/8/2024 at 12:29 PM, there was no gravy on the tacos. The DS stated they only serve gravy on soft mechanical (diet that contained chopped foods) and puree (diet that contained foods with pudding like consistency) diets, however the daily spreadsheet indicated all the diets would get gravy. The DS stated she was not sure of the potential outcome for residents for not getting the gravy. During an interview with Registered Dietitian 1 on 7/8/2024 at 12:42 PM, RD 1 stated they follow the menu spreadsheet and serve the exact foods to the residents because of its nutritional content, calories, and nutrients. RD 1 stated the menu indicated regular consistency trays would get gravy. RD 1 stated the potential outcome to the residents were less calorie and nutrient intake leading to weight loss. RD 1 stated it could also affect the taste of the food leading to dissatisfaction to the residents. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's Policies and Procedures (P&P) titled, Menus, dated 4/11/2024 indicated Menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. (1) Menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board (National Research Council and National Academy of Sciences). (8) Menu provides a variety of foods from the basic daily food groups and indicate standard portions at each meal. A review of P&P titled, Standardized Recipes, dated 4/11/2024 indicated, Standardized recipes shall be developed and used in the preparation of foods. A review of P&P titled, Food and Nutrition Services, dated 7/9/2024 indicated food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident.

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F 0804

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.

47441

Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved appetizing temperatures when cold foods were in the danger zone (a range of temperature 41 degrees Fahrenheit ([F], a scale of temperature) to 135 F in which bacteria grow rapidly) during trayline service. This deficient practice placed 44 of 45 facility residents at risk of unplanned weight loss, a consequence of poor food intake, getting food from the kitchen.

Findings:

A review of the facility's menu spreadsheet (a list containing types and amount of foods of what each diet type would receive) titled Daily Spreadsheet dated 7/8/2024, Monday, indicated regular, no added salt ([NAS], no salt packets on the tray), and consistent carbohydrate (diet that contained same serving of carbohydrate per meal aim to control blood glucose levels),NAS diet included the following food items on the tray:

-Pork carnitas one (1) each

-Great northern beans 1/2 cup ([c], a unit of measurement)

-Gravy 1 oz

-Fresh beets with orange 1/2 c

-Flour tortilla 1 each

-Choice of beverage 1 c

-Apple pie 1/10 pie

A review of the facility's recipe titled 'pork carnitas tacos 2 ounces' ([oz], a unit of measurement), undated, indicated the ingredients were shredded iceberg lettuce, fresh tomatoes, and shredded cheese.

During a concurrent trayline observation and interview with the Dietary Supervisor (DS) on 7/8/2024 at 11:56 AM, fresh beets with oranges was and pork carnitas were at 167 F, fresh beets with oranges were at 60 F, cheese at 55 F, tomatoes at 55 F and lettuce at 61 F. The DS stated they would put the cold foods on ice to make the food cold.

During a test tray conducted with the Dietary Supervisor (DS) on 7/8/2024 at 12:29 PM for regular diet (diet with no restrictions), the pork carnitas tacos with shredded cheese, shredded lettuce and tomatoes were 119 F and fresh beets with oranges were at 55 F. The DS stated the cold food temperature was not acceptable and should be at a temperature of less than 40 F as it might not be appetizing to the residents. The DS stated the potential outcome would be residents would start complaining because the temperature would not be as what they expected it to be.

(continued on next page)

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 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Healthcare Center	2625 Maple Ave. Los Angeles, CA 90011

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policies and procedures (P&P) titled, Food and Nutrition Services. dated 7/9/2024, indicated each resident was provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preference of each resident. (7) Food and nutrition service staff will inspect trays to ensure that the correct meal was provided to each resident, the food appears palatable and attractive, and was served at a safe and appetizing temperature.

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 07/11/2024
NAME OF PROVIDER OR SUPPLIER: Maple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2625 Maple Ave. Los Angeles, CA 90011	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen, including cross-contamination (transfer of harmful bacteria from one place to another), cleanliness of kitchen equipment, and hand hygiene. These failures had the potential to result in harmful bacteria growth and cross contamination which could lead to foodborne illness (transfer of bacteria from one object to another) in 44 of 45 medically compromised residents who received food and ice from the kitchen. Findings: A. a) During an initial kitchen tour observation on [DATE] at 8:11 AM, the Dietary Supervisor (DS) was not wearing hairnet while working in the kitchen. The hairnet was not available in the front entrance instead hairnets were in the back entrance door. During an interview on [DATE] at 8:15 AM, the DS stated the hair box on the front entrance broke last Friday and she was not able to have it fixed, as she was not here last Friday. The DS stated it was important to have hairnets available by the kitchen entrance because they worked with food and to ensure that hair would not fall into food and drinks. The DS stated the potential outcome for the residents would be cross-contamination. A review of the facility's Policies and Procedures (P&P) titled Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices dated [DATE], indicated 12. Hair nets or caps and or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens. b) During an initial kitchen tour observation on [DATE] at 8:11 AM, the trash can by the hand washing sink was not covered. During an observation near the preparation areas on [DATE] at 11:29 AM, two (2) black trash cans had no cover while not actively used. A review of the facility's P&P titled Food-Related Garbage and Refuse Disposal dated [DATE], indicated (2) All garbage and refuse containers are provided with tight fitting lids or covers and must be kept covered when stored or not in continuous use. c) During an initial kitchen tour observation on [DATE] at 8:11 AM, the handwashing sink was located side by side a rack containing salt packets, glasses, and other small kitchen equipment without a splash guard. During concurrent observation and interview with the DS on [DATE] at 9:26 AM, the DS stated the water from the sink was going to the condiments making them wet hence they could not use the salt and sugar packets due to cross contamination. (continued on next page)

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 07/11/2024
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled Food Preparation dated [DATE], indicated (6) Handwashing sinks are located near food preparation and clean dishes and are separate from ware washing sinks. d) During concurrent observation of the dry storage area and interview with DS on [DATE] at 8:52 AM, a shelf was three (3) in., above the ground. DS stated shelves had to be six (6) in. or more so they could clean below it and see the pest like ants. DS stated if the shelves were too low to the ground, other items and supply could be contaminated. During concurrent observation of the condiment rack and interview with DS on [DATE] at 11:33 AM, the condiment rack was 3 in. high when measured using a tape measure. DS stated the rack must be 6 in. to prevent cross-contamination. A review of the facility's P&P titled Food Receiving and Storage dated [DATE], indicated (6) Food in designated dry storage areas shall be kept off the floor (at least 18 inches) and clear of sprinkler heads, sewage/waste disposal pipes and vents. e) During an observation of the uncovered trash can while not in use on [DATE] at 9:20 AM, the trash can was overflowing with soiled paper towels, and it was going to the clean bowls stored on a shelf near the dishwashing sink. During a concurrent observation and interview with DS on [DATE] at 9:24 AM, DS stated she was aware that the trash can was not covered while not in use however, these were the only trash cans that they have. DS stated the trash was contaminating the clean bowls. A review of the facility's P&P titled Food-Related Garbage and Refuse Disposal dated [DATE], indicated (2) All garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use. f) During concurrent observation of the thawing process in the two-compartment sink and interview with DS on [DATE] at 9:23 AM, two (2) soiled pans were in the sink alongside the thawing ham. DS stated the dirty pans must not be in the thawing sink due to cross-contamination. A review of the facility's P&P titled Food Preparation and Service dated [DATE], indicated (4) Appropriate measures are used to prevent cross-contamination. g) During concurrent observation and interview with DS on [DATE] at 11:33 AM, a blue crate where paper containers were stored was on the floor. DS stated they used the paper containers as a backup when they run out of dishes. DS stated it had to be stored above the floor to prevent cross-contamination. A review of the facility's P&P titled Food Receiving and Storage dated [DATE], indicated (6) Food in designated dry storage areas shall be kept off the floor (at least 18 inches) and clear of sprinkler heads, sewage/waste disposal pipes and vents. A review of Food Code 2017, indicated, ,d+[DATE].113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment. (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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Healthcare Center	2625 Maple Ave. Los Angeles, CA 90011

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Food Code 2017 indicated ,d+[DATE].11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under Subparts [DATE]-306. A review of Food Code 2017, indicated ,d+[DATE].11 Packaged and Unpackaged Food-Separation, Packaging, and Segregation. (A) Food shall be protected from cross-contamination. (2) Except when combined as ingredients, separating types of raw animals from each other such as beef, fish, lamb, pork, and poultry during storage, preparation, holding, and display by: (b) Arranging each type of food in equipment so that cross-contamination of one type with another is prevented and (c) Preparing each type of food at different times or in separate areas. A review of Food Code 2017 indicated ,d+[DATE].11 Food Storage (A) Except as specified in (B) and (C) of this section, food shall be protected from contamination by storing the food: (3) at least 15 cm (6 inches) above the floor. B. a) During an initial kitchen tour observation of the refrigerator near the back door on [DATE] at 8:21 AM, the refrigerator vent had black residue and yellow sticky particles. b) During an initial kitchen tour observation of the refrigerator near the back door on [DATE] at 8:23 AM, the refrigerator shelves were not smooth, had crack and amber discoloration. c) During an initial kitchen tour observation of the freezer near the back door on [DATE] on 8:28 AM, freezer gasket door had black dirt buildup. d) During an initial kitchen tour observation of the refrigerator near the front entrance on [DATE] at 8:31 AM, refrigerator gasket door had brown dirt buildup. During concurrent observation of the refrigerators near the back door and front door and freezer near the back door and interview with DS on [DATE] at 8:35 AM, DS stated the freezers and refrigerators were cleaned twice a week every Monday and Thursday. DS stated the refrigerator and freezer had to be cleaned as it could get residents sick with symptoms of fever, throwing up, body weakness. DS stated the refrigerator was old and shelves needed to be changed as the color was coming off and could go to the food, they could cause cross-contamination. DS stated the gasket was not clean and the staff did not clean it as the gaskets had dirt buildup. e.) During a concurrent observation of the freezer inside the dry storage area and interview with DS on [DATE] at 8:52 AM, freezer had black dirt residue. DS stated the freezer will be cleaned today to prevent cross-contamination. A review of the facility's P&P titled Refrigerator and Freezers dated [DATE], indicated This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. 9. Supervisors will inspect refrigerators and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and any damage or maintenance needs. Necessary repairs will be initiated immediately. Maintenance schedules per manufacturer guidelines will be scheduled and followed. 10. Refrigerator and freezers will be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f) During an observation of the condiment area on [DATE] at 11:19 AM, the container for plastic spoon and forks had dirt residues. g) During an observation of the condiment area on [DATE] at 11:20 AM, the black pepper and Chinese granulated garlic containers had dirt buildup. h) During a concurrent observation and interview with DS on [DATE] at 11:24 AM, the can opener had dirt buildup. DS stated the can opener must be cleaned after use however there was a dirt buildup that needed to be cleaned. During an interview with DS on [DATE] at 11:27 AM, DS stated she was the only one cleaning the spices and the can opener and told her staff plenty of times to clean however they started ignoring her. DS stated they have a cleaning schedule, and the staff knew exactly what to do and clean. i) During concurrent observation and interview with DS on [DATE] at 11:26 AM, the knife container had dust and dirt. DS stated the knife in the knife container was not being used but needed to be cleaned to prevent cross contamination. j) During an observation of the dry storage area on [DATE] at 11:44 AM, the vent had dust buildup. During concurrent observation of the dry storage vent and interview with DS on [DATE] at 11:38 AM, DS stated she did not think staff cleaned the vent as it had dust buildup. DS stated it was important to clean the vent as the dust could go to the food and it could cause cross-contamination. A review of the facility's P&P titled Sanitization dated [DATE] indicated The food service area shall be maintained in a clean and sanitary manner. (1) All kitchens, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies, and other insects. (2) All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. (3) All equipment, food contact surfaces shall be washed to remove or completely loosen soils by using manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. k) During concurrent review of the chlorine test paper label and interview with Dietary Aide 3 (DA 3) on [DATE] at 11:10 AM, chlorine test paper indicated an expiry date of ,d+[DATE]. During a concurrent review of the chlorine test strips and interview with DS on [DATE] at 11:26 AM, DS stated the chlorine test strips were no longer good to use as it was expired with a date of ,d+[DATE]. DS stated she ordered new ones, but it has not come yet. DS stated the expired test strips would not show accurate results of chlorine concentration therefore they were not sure if the dishmachine was sanitizing dishes properly. DS stated residents could have fever due to germs in the dishes as a potential outcome. During a concurrent review of the Hydrion T-10 test strips (test strips that measures QUAT sanitizer concentration) and interview with DS on [DATE] at 11:34 PM, the Hydrion T-10 test strips had an expiration date of [DATE]. DS stated the QUAT sanitizer was used to sanitize kitchen surfaces and an expired test strips would not measure accurate concentration. DS stated potential outcome could be cross-contamination. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Maple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2625 Maple Ave. Los Angeles, CA 90011	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	l) During an observation of dishwashing process by DA 1 and DS on [DATE] at 8:47 AM, DA 1 and DS did not air dry the plates and trays and stacked the trays and plates wet. During concurrent observation of dishwashing process and interview with DS on [DATE] at 8:58 AM, DS stated the last step of dishwashing was air drying and they were not allowed to wipe the dishes with a towel. DS stated the cups were stacked wet and it was an okay practice because it needed to be air dried. DS stated the cups should be dried one at a time and it was okay to stack them wet. DS stated DA 1 was trained by the staff that had three (3) years of experience. A review of the facility's P&P titled Dishwashing Machine Use dated [DATE] indicated Food staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation. A review of the facility's P&P titled Sanitation dated [DATE] indicated (10) Food preparation equipment and utensils that are manually washed will be allowed to air dry whenever practical. m) During concurrent observation of dishwashing process and interview with DA 1 on [DATE] at 9:11 AM, DA 1 stated he scraped the trash from the soiled dishes, placed the dishes in dishmachine and checked the machine temperature in the morning. DS 1 stated the dishmachine temperature had to be 110 F to 120 F. DS 1 got the Quat sanitizer test strip and measured the temperature of the machine however after being coached by co-workers, he got the chlorine test strips. DS 1 got the chlorine test strips and pulled one strip and run the machine. DS 1 lifted the dishmachne door after five (5) seconds then dipped the chlorine test strip. DA 1 stated the test strip turned purple and it indicated 120 F. During concurrent observation of the dishwashing process and interview with Dietary Aide 4 on [DATE] at 11:00 AM, DA 4 stated he helped with dishwashing but needing to ask as how to check the temperature of the dishmachine. DA 4 stated he has not done a whole lot of the washing, but he knew the temperature was at 120 F. A review of the facility's P&P titled Dishwashing Machine Use dated [DATE], indicated (7) The operator will check temperature using the machine gauge with each dishwashing machine cycle and will record the results in a facility approved log. The operator will monitor gauge frequently during dishwashing machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately. A review of the facility's P&P titled Sanitation dated [DATE], indicated Dishwashing machines must be operated using the following specifications: Low temperature dishwasher (chemical sanitation) (a) wash temperature (120 F). n) During a concurrent demonstration of the dishmachine chlorine concentration testing and interview DA 4 on [DATE] at 11:00 AM, DA 4 dipped the chlorine test strips and compared it to the color chart and stated 50 parts per million ([ppm] measure of concentration) was not a good concentration. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent demonstration of the dishmachine chlorine concentration testing and interview with Dietary Aide 3 (DA 3) on [DATE] at 11:00 AM, DA 3 stated it was the second cycle of the dishmachine when she checked the chlorine concentration in the dishmachine. DA 3 dipped and shook the chlorine test strip for four (4) seconds then compared it to the color chart. DA 3 stated it was important to follow manufacturer's guidelines to make sure the chlorine was in the right concentration and that it was cleaning the dishes. DA 3 stated if the chlorine was not in the right concentration, it would not clean the dishes and could get the residents sick such as stomach flu. During concurrent review of the chlorine test paper and interview with DA 3 on [DATE] at 11:35 AM, chlorine test strip manufacturer's guidelines indicated Lot 101221 Expiration date ,d+[DATE]. Dip one test strip into solution without agitation. Blot dry. Compare immediately to color chart. DA 3 stated she did not follow the chlorine manufacturer's guidelines. During an interview with DS on [DATE] at 11:26 AM, DS stated it was important to follow the chlorine test strips manufacturer's guidelines to ensure the chlorine concentration was accurate to sanitize dishes. DS stated potential outcome to the residents would be they could get sick of fever because of germs in the dishes. A review of facility's P&P titled Dishwashing Machine Use dated [DATE], indicated Dishwashing machine chemical sanitizer concentrations and contact times will be as follows: chlorine ,d+[DATE] ppm with 10 seconds contact time. A review of Food Code 2017 indicated ,d+[DATE].13 Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. A review of Food Code 2017 indicated ,d+[DATE].11 (A) Equipment Food Contact Surfaces and utensils shall be clean to sight and touch. ,d+[DATE].10 Food Contact Surfaces and Utensils shall be sanitized. , d+[DATE].11 Before use After cleaning. Utensils and Food-Contact Surfaces of Equipment shall be sanitized before use after cleaning. A review of Food Code 2017 indicated ,d+[DATE].11 (A) Equipment Food Contact Surfaces and utensils shall be clean to sight and touch. (B) NonFood-Contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. A review of Food Code 2017 indicated ,d+[DATE].11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. A review of Food Code 2017 indicated ,d+[DATE].11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining. (B) May not be cloth dried. A review of Food Code 2017, indicated ,d+[DATE].110 Mechanical Warewashing Equipment Wash Solution Temperature (B) The temperature of the wash solution in spray-type warewashers that use chemicals to sanitize may not be less than 120 F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Food Code 2017 indicated ,d+[DATE].116 Warewashing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. A review of Food Code 2017 indicated ,d+[DATE].114 Manual and Mechanical Warewashing Equipment, Chemical Sanitation- Temperature, pH, Concentration, and Hardness. Verifying the adequacy of chlorine-based solutions can be accomplished on an on-going basis by confirming that the concentration, temperature, and pH of the sanitizing solutions comply with paragraphs ,d+[DATE].114 (A) using acceptable test methods and equipment. The manufacturer should provide methods (e.g. test strips, kits, etc.) to verify that the equipment consistently generates solution on-site at the necessary concentration to achieve sanitation. C. a) During concurrent observation of the thawing process in the two-compartment sink and interview with [NAME] 1 on [DATE] at 9:06 AM, there was ham in a shallow pan under a running water. [NAME] 1 stated she usually thaw in the refrigerator for three (3) days, however she forgot to pull the ham from the freezer, placed it in the sink because she needed it today. [NAME] 1 stated she took the ham out at five (5) AM. During an interview with DS on [DATE] at 9:09 AM, DS stated they thaw in the refrigerator for 3 days however her staff did not take the pork out. DS stated they put meat in the sink under running water to defrost perfectly and start preparing the meal. DS stated they use cold water in defrosting using the sink method however they do not water temperature. DS stated it would take two (2) hours maximum to thaw in the sink however they do not monitor time. DS stated they have to put the ham back in the refrigerator after 2 hours. DS stated they do not have a log as to what time they took it out, but the ham was out since 5 AM. During an observation and interview of DS on [DATE] at 9:41 AM, the ham thawed in the sink was in the refrigerator with a temperature of 69 F. DS stated the ham was no longer safe for consumption as the temperature was not safe and the process of thawing was not right. DS stated the resident could get sick but could not remember what kind of sickness as a potential outcome. A review of the facility's P&P titled Food Preparation and Service dated [DATE] indicated Thawing frozen food (1) Foods will be thawed at room temperature. Thawing procedures include: a. thawing in the refrigerator in a drip-proof container. b. completely submerging the items in cold running water (70 F or below) that is running fast enough to agitate and remove ice particles. (4) Potentially hazardous foods held in the danger zone for more than 4 hours (if being prepared from ingredients at room temperature) or 6 hours (if cooked and then cooled) may cause foodborne illness. A review of the facility's P&P titled Food Code Temperatures dated [DATE], indicated raw animal products temperature must not be above 41 F for more than 4 hours of cumulative time. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Food Code 2017 indicated ,d+[DATE].13 Thawing. (B)Completely submerged under running water: (1) At a water temperature of 21 F (70 F) or below, (4) For a period of time that does not allow thawed portions of a raw animal food requiring cooking as specified under ,d+[DATE].11 (A) or (B) to be above 5 C (41 F), for more than 4 hours including: (a) The time food is exposed to the running water and the time needed for preparation for cooking. b. During concurrent trayline observation and interview with DS on [DATE] at 11:56 AM, fresh beets with orange was at pork carnitas was at 167 F, fresh beets with oranges were at 60 F, cheese at 55 F, tomatoes at 55 F and lettuce at 61 F. DS stated they will put the cold foods on ice to make the food cold. During a test tray conducted with the DS on [DATE] at 12:29 PM for regular diet (diet with no restrictions), pork carnitas tacos with shredded cheese, shredded lettuce and tomatoes was t 119 F and fresh beets with oranges was at 55 F. DS stated the cold food temperature was not acceptable and should be at a temperature of less than 40 F for food safety. DS stated the potential outcome could get the residents sick. A review of the facility's P&P titled Food Preparation and Service dated [DATE] indicated Food Preparation, Cooking and Holding Time/Temperatures. (1) The danger zone for food temperatures is between 41 F and 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. (3) The longer food remains in the danger zone the greater the risk for growth of harmful pathogens. Therefore, PHF must be maintained below 41 F and above 135 F. c) During concurrent observation of the Resident's refrigerator and interview with Activities Director (AD) on [DATE] at 11:45 AM, there was no thermometer inside the resident's refrigerator. AD stated it was important to monitor the refrigerator's temperature to ensure the resident's food was safe to eat. AD stated residents could be eating spoiled food that could cause vomiting as a potential outcome for the residents. A review of the facility's P&P titled Refrigerator and Freezers dated [DATE], indicated This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. (1) Acceptable temperature ranges are 35 F to 40 F for refrigerators and less than 0 F for freezers. d) During concurrent observation of the Resident's refrigerator and interview with AD on [DATE] at 11:45 AM, salami had no expiration date, six (6) kimchi packets were expired on [DATE]. AD stated they label resident's food with name, received date, room number and expiry date. AD stated they keep residents' food for no more than two (2) days and threw expired food as it would no longer be good and safe for human consumption. AD stated residents could get sick of food poisoning as a potential outcome. (continued on next page)

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

A review of the facility's P&P titled Food Bought by Family/Visitors dated [DATE], indicated Food bought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. (5) Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that is clearly distinguishable from facility-prepared food. (b) Perishable foods are stored in resealable container with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. (6) Nursing staff will discard perishable foods on or before the use by date.

A review of Food Code 2017, indicated ,d+[DATE].16 Time/Temperature for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as a public health control as specified under ,d+[DATE].19, and except as specified under (B) and in (C) of this section, Time/Temperature Control for safety food shall be maintained: (2) At 5 C (41 F) or less.

A review of Food Code 2017 indicated, ,d+[DATE].112 Temperature Measuring Devices. (A) In a mechanically refrigerated or hot Food Storage unit, the sensor of a temperature Measuring Device shall be located to measurer the air temperature or a simulated product temperature in the warmest part of the mechanical refrigerated unit and in the coolest part of a hot food storage unit.

A review of Food Code 2017 indicated ,d+[DATE].17 Commercially processed food, open and hold cold, (B) except specified in (E) - (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacture's use-by- date if the manufacturer determined the use-by date based on food safety.

D. a) During an observation of DA 1 handwashing and interview with DA 1 on [DATE] at 11:47 AM, DA 1 touched the faucet dial, dried his hands then picked up a trash from the floor. DA 1 washed his hands with water without using soap and went back to work. DA 1 stated it was important to wash hands when touching trash to prevent contamination and bacteria going to the hands. DS 1 stated possible outcome could be contamination of resident's food with bacteria that would get them sick.

During an interview with Dietary Aide 2 (DA 2) on [DATE] at 11:50 AM, DA 2 stated not performing handwashing after picking up a trash was not a good practice because bacteria could get into your hands that could get to the food that they prepare that residents consume. DA 2 stated residents could get sick.

A review of the facility's P&P titled Handwashing/Hand Hygiene dated [DATE] indicated Procedure of washing hands: 1. Wet hands first with water, then apply an amount of product recommended by the manufacturer to hands. 2. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 3. Rinse hands with water and dry thoroughly with a disposable towel. 4. Use towel to turn off the faucet. 5. Avoid using hot water, because repeated exposure to hot water may increase the risk of dermatitis.

(continued on next page)

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 07/11/2024
NAME OF PROVIDER OR SUPPLIER: Maple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2625 Maple Ave. Los Angeles, CA 90011	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b) During an observation of the dishwashing process on [DATE] at 8:25 AM, DA 1), DA 1 touched the cleaned dishes then put away the clan dishes without washing hands or changing gloves. During concurrent observation of DA 1 dishwashing and interview with DS on [DATE] at 8:30 AM, DS stated staff could not change their gloves each time they go from dirty to clean as this was her first-time hearing that. DS stated she was not sure if this practice was acceptable and needed to ask her counselor. During an interview with Infection Prevention Nurse (IPN) on [DATE] at 9:21 AM, IPN stated staff should perform handwashing or hand hygiene when touching dirty items before handling clean items. IPN stated anything that would contaminate the hands with microscopic (anything that could not be seen with the naked eye) bacteria could cause vomiting and diarrhea to the residents. A review of the facility's policy and procedure (P&P) titled Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices dated [DATE], indicated Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. (6) Employees must wash their hands: (f) After handling soiled equipment or utensils; (h) after engaging in other activities that contaminate the hands. A review of the facility's P&P titled Dishwashing Machine Use dated [DATE] indicated The following guidelines will be followed when dishwashing: (a) wash hands before and after running dishwashing machine, and frequently during the process. A review of the facility's P&P titled Handwashing/Hand Hygiene dated [DATE], indicated The facility considers hand hygiene the primary means to prevent the spread of infections (1) All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing transmission of healthcare-associated infections. (2) All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. d. During an observation of [NAME] 2 while preparing food on [DATE] at 12:19 PM, [NAME] 2 had beard and was not wearing a beard guard. During an interview with DS on [DATE] at 11:40 AM, DS stated staff needed to wear beard guard to protect hair from going to the food that could result from cross-contamination. A review of the facility's Policies and Procedures (P&P) titled Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices dated [DATE], indicated 12. Hair nets or caps and or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens. A review of Food Code 2017 indicated ,d+[DATE].12 Cleaning Procedure. (C) To avoid decontaminating their hands or surrogate prosthetic devices, food employees may use disposable paper towels or similar clean barriers when touching surfaces such as manually operated faucet handles on a handwashing sink or handle of a restroom door. A review of Food Code 2017 indicated ,d+[DATE].14 When to wash. (I) After engaging in other activities that contaminate the hands. (continued on next page)

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	055036	A. Building B. Wing	07/11/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Food Code 2017 indicated -,d+[DATE].11 Effectiveness. (A) Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings, or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped singles service and single-use articles.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 47441 Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly by not maintaining the trash area free from excess trash, plastic, empty plastic bottles, soiled gloves, and other dirt debris. This deficient practice had a potential to attract birds, flies, insects, pest and possibly spread infection to 44 of 45 facility residents. Findings: During an observation of the dumpster area outside of the facility on 7/8/2024 at 11:40 AM, plastic bottles, paper, soiled gloves, trash was on the ground. During a concurrent interview the Dietary Supervisor (DS) stated the trash fell from the trash bins during the truck garbage collection and that it was important to maintain the cleanliness of the garbage for infection and pest control as it would prevent flies and mice from going in the kitchen. The DS stated it was housekeeping responsibilities to maintain the cleanliness of the area. During an interview with the Housekeeping Supervisor (HKS) on 7/9/2024 at 10:46 PM, she stated she was responsible for cleaning the trash area and that they clean it every Monday and Friday. The HKS stated it was important to maintain the cleanliness of the trash surroundings for infection control and that the trash could fall off on to the ground during trash collection. A review of the facility's policies and procedures (P&P) titled, Food-Related Garbage and Refuse Disposal, dated 4/11/2024, indicated food-related garbage and refuse are disposed of in accordance with the current state laws. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. A review of Food Code 2017, indicated, 5-501.15 Outside receptacles. (A) Receptacles and waste handling units for Refuse, recyclables, and returnable used with materials containing Food residue and used outside the Food Establishment shall be designed and constructed to have tight-fitting lids, doors, or covers. A review of Food Code 2017, indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to maintain a complete and accurate medical record by failing to record administered doses of clonazepam (Klonopin, a medication used to treat mental illness) for one of five sampled residents (Resident 45) observed for medication administration in the Medication Administration Record (MAR - a record of all medications administered, and monitoring performed for a resident) between 7/4/24 and 7/9/24. The deficient practice of failing to record administered doses of Klonopin in the MAR increased the risk that Resident 45 could have experienced medical complications related to administering Klonopin too frequently, possibly resulting in hospitalization . Findings: A review of Resident 45's Admission Record indicated she was admitted to the facility on [DATE] with diagnoses including anxiety disorder (a mental health disorder characterized by feeling or worry or fear that are strong enough to interfere with daily activities). A review of the History and Physical dated 1/11/24, indicated Resident 45 was competent to understand her medical condition. A review of Resident 45's available Physician's Orders indicated there was no current order in Resident 45's clinical record for Klonopin 0.5 mg between 7/4/24 and 7/9/24. A review of Resident 45's MAR for July 2024 indicated there was no recorded doses of Klonopin or ability to record doses of Klonopin between 7/4/24 and 7/9/24. During an observation on 7/9/24 at 8:21 AM, Resident 45 was observed taking one tablet of Klonopin 0.5 milligrams (mg - a unit of measure for mass) prepared by the Licensed Vocational Nurse (LVN 1). During a concurrent observation of the pharmacy label Resident 45's Klonopin was filled on 7/4/24. During an interview on 7/9/24 at 9:58 AM, LVN 1 stated he administered Klonopin for Resident 45 this morning despite having no record of a physician's order in the resident's clinical record. LVN 1 stated he administered it because the pharmacy filled it recently on 7/4/24, the medication was available in the cart, and the MAR contained orders to monitor for adverse effects and behaviors related to its use. LVN 1 stated he failed to see that there was no way to record the administration of the Klonopin in the MAR since there was currently no record of an active physician's order. LVN 1 stated he should have held the medication and clarified whether there was an active physician's order for Resident 45's Klonopin prior to administering the medication. LVN 1 stated administering medications without an order or without a record of when it was given, increased the risk that Resident 45 could have experienced medical complications long-term possibly resulting in hospitalization . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Administering Medications, revised April 2019, indicated medications were administered in a safe and timely manner, and as prescribed. Medications were administered in accordance with prescriber orders, including any time frame. The individual administering the medication checks the label THREE (3) times to verify the right medication before giving the medication. The individual administering the medication initials on the resident's MAR on the appropriate line after giving each medication and before administering the next ones. A review of the facility's policy titled, Documentation of Medication Administration, last revised April 2007, indicated the facility shall maintain a medication administration record to document all medications administered. A nurse shall document all medication administered to each resident on the resident's medication administration record (MAR.) Administration of medication must be documented immediately after (never before) it is given.

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on observation, interview, and record review, the facility failed to ensure room [ROOM NUMBER] and room [ROOM NUMBER] had no more than two residents. This failure had the potential to have an adverse effect on the health and safety of the residents in room [ROOM NUMBER] and room [ROOM NUMBER] and impede the ability of any resident in the room to attain his or her highest practicable well-being. Findings: During an observation on 7/8/2024 at 8:05 AM of room [ROOM NUMBER], a total of six residents were in each room. During a concurrent interview Resident 14 stated he had no issues with his room and liked where he was at. Resident 14 stated he had enough space for his belongings and did not have any complaints. During an interview with the Licensed Vocational Nurse (LVN 3) on 7/10/2024 at 1:33 PM, LVN 3 stated she did not have any issues with the room space when providing care for the residents. During an interview on 7/9/2024 at 7:22 AM, the facility Administrator (ADM) stated she was unsure as to when or why six residents were moved into room [ROOM NUMBER] and room [ROOM NUMBER] and the ADM also stated there was no room waiver for room [ROOM NUMBER] or room [ROOM NUMBER]. A review of the facility's policy revised May 2017 and titled, Bedrooms, indicated all residents were provided with clean, comfortable, and safe bedrooms that meet federal and state requirements and bedrooms must accommodate no more than two residents at a time.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851 Based on observation, interview and record review, the facility failed to ensure 14 of 20 resident rooms (room [ROOM NUMBER], 2, 4, 6, 7, 8, 9, 10, 11, 14, 17, 18, 19, and 20) met the space requirements of 80 square feet for each resident in multiple resident bedrooms. This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for the impacted residents. Findings: On 7/8/2024 at 8:31 AM to 9:44 AM during a general tour of the facility, Rooms 1, 2, 4, 6, 7, 8, 9, 10, 11, 14, 17, 18, 19, and 20 were observed. room [ROOM NUMBER] and room [ROOM NUMBER] were observed with 6 residents each. The rooms were observed with enough space for nursing staff to provide care to the residents in the rooms. The rooms were observed with privacy curtains for each resident and with direct access to the corridors. During the resident council meeting (an organized group of residents who meet regularly to discuss and address concerns about their rights, quality of care, and quality of life) on 7/9/2024 at 10:16 AM, there were no concerns brought up by residents who attended the meeting regarding the size of the residents' rooms. A review of the Client Accommodations Analysis dated 7/8/2024, indicated the following rooms with their corresponding measurements: Room # # of beds Total Square Feet 1 6 455.0 2 3 220.0 4 3 220.0 6 3 455.0 7 3 220.0 8 3 220.0 9 3 234.0 10 6 455.0 11 3 220.0 14 3 220.0 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	17 3 222.0 18 3 222.0 19 3 222.0 20 3 222.0 The Client Accommodation Analysis indicated the above rooms measured less than the required 80 square footage per resident in multiple resident bedrooms. For a three-bed capacity room, the square footage requirements would be at least 240 square feet. For a six-bed capacity room, the square footage requirements would be at least 480 square feet. A review of a letter from the Administrator dated 7/9/2024, indicated the Administrator was requesting a waiver for rooms 1, 2, 4, 6, 7, 8, 9, 10, 11, 14, 17, 18, 19, and 20. The letter indicated that the rooms were in accordance with the special needs of the residents and would not have an adverse effect on residents' health and safety or impede the ability of any residents in the rooms to attain his or her highest practicable well-being. During a concurrent observation and interview on 7/10/2024 at 12:53 PM, room [ROOM NUMBER] was observed with three residents. Resident 11 was observed in the room with a wheelchair at bedside. Resident 11 was observed with a dresser and bedside table. No obstructions were observed in room [ROOM NUMBER]. Resident 11 stated there was no issues with the space in her room. Resident 11 stated the nurses had enough space to get around when they come into their room. Resident 11 stated they were happy with the space they had in the room. During an interview on 7/10/2024 at 12:56 PM Certified Nursing Assistant (CNA) 2 stated they can move things around to maneuver in the residents' room. CNA 2 stated they did not feel like they bumped into things when performing duties in the residents' rooms. During an interview on 7/10/2024 at 12:58 PM, CNA 3 stated there was enough room to do everything they needed to do in all the residents' room. CNA 2 stated none of the residents every complained to them about the size of the room. During a concurrent observation and interview on 7/10/2024 at 1:05 PM, room [ROOM NUMBER] was observed with three beds. Resident 45 was observed in the room with a cane at bedside, a dresser, and a bedside table. Resident 45 stated she had no issues with the space in the room. Resident 45 stated she was able to ambulate with her cane easily in the room. The room waiver was recommended to continue and was contingent with federal regulations at accommodation of needs (483.15 e) and Resident Rights (483.10).

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49836 Based on observation, interview, and record review, the facility failed to maintain a safe, comfortable environment for one sample resident (Resident 44). Resident 44's toilet seat was not secure which had the potential to place the resident at risk for injury. Findings: During an observation on 7/8/2024 at 8:29 AM, Resident 44's the toilet seat not secured. During a concurrent interview, Resident 44 stated the toilet seat in his bathroom was wiggly and that it was difficult for him to get up from the toilet seat because it was loose. Resident 44 also stated that he informed staff, but no one had come to fix it. During an interview on 7/9/2024 at 7:29 AM, Licensed Vocational Nurse (LVN) 2 stated that when there was a maintenance request it was written down in the maintenance log located in the nursing station. LVN 2 stated she was unaware of the loose toilet seat for Resident 44 and that the resident's toilet seat should not be loose. LVN 2 stated it was a safety hazard for the resident and she would request for the toilet seat to be fixed. During an interview with the Maintenance Supervisor (MS) on 7/9/2024 at 12:56 PM, the MS stated maintenance requests were requested using the maintenance log located in the nursing station and that he checked the maintenance log at least twice a day. During a concurrent observation, the MS saw the toilet seat and stated it was loose and that it was a safety hazard for the residents. The MS stated that no staff informed him of the loose toilet seat. The MS checked the maintenance log and saw no request had been made. A review of the facility's policy and procedure titled, Homelike Environment, reviewed 4/11/2024, indicated residents were provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. Staff provides person-centered care that emphasized the residents' comfort, independence, and personal needs and preferences. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting, These characteristics include: clean, sanitary, and orderly environment, clean bed and bath linens that are in good condition. A review of the facility's policy and procedure titled, Maintenance Service, reviewed 4/11/2024, indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. The maintenance department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 47441 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the food services department when two flies were observed in the kitchen. This deficient practice had a potential to result in 44 of 45 residents, who received food from the kitchen, to acquire food borne illnesses (caused by consuming contaminated foods or beverages) by consuming potentially contaminated food. Findings: During an observation of the facility's kitchen back door on 7/8/2024 at 8:20 AM, the back door was wide open. During concurrent observation of the facility's kitchen and interview with the Dietary Supervisor (DS) on 7/8/2024, at 9:29 AM, the DS stated the back door had been open since this morning and they kept it open because it was too hot in the kitchen, but the door was usually closed. During concurrent observation of the lunch trayline (an area where resident's food was assembled) and interview with the DS on 7/8/2024 at 12:06 PM, there was a fly flying around the trayline area. The DS stated the fly came from the outside because the back door was opened and that the potential outcome would be flies could go to the food and could bring dirt to the food causing cross-contamination. During an observation of the employees dishing out food for the residents on 7/8/2024 at 12:27 PM, there was a fly flying around the trayline area. A review of facility's Policy and Procedure (P&P), titled, Pest Control, dated 4/11/2024, indicated the facility shall maintain and effective pest control program and that the facility maintained an on-going pest control program to ensure that the building was kept free of insects and rodents.