STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	12/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to report an allegation of abuse for two of three sampled residents (Resident 1 and Resident 2) within 2 hours to the ombudsman, local police department, and to California Department of Public Health (CDPH) in accordance with the facility's Policy and Procedure titled, Abuse and Neglect Prohibition Policy. On 12/21/25 between 5 PM and 6 PM, a commotion was heard by certified nurse assistant (CNA) 1 and when CNA1 arrived at Resident 1 and Resident 2's room [room [ROOM NUMBER]], Resident 1 was observed with a slipper in her hand, and Resident 2, reported to CNA 1 that Resident 1 threatened to hit Resident 2 with the slipper. This deficient practice resulted in the facility underreporting allegations of abuse and had the potential for the facility not to follow abuse protocols. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 1/16/2025 with diagnoses that included paranoid schizophrenia (a serious brain disorder that distorts a person's thinking, perception of reality, and emotions) and bipolar disorder (a mental health condition causes extreme mood swings). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 12/12/2025, the MDS indicated Resident 1 had severely impaired cognition (ability to understand and make decisions) and memory. The MDS also indicated Resident 1required supervision or touching assistance with eating, partial/moderate assistance with oral hygiene, personal hygiene and chair/bed-to-chair transfer, and substantial/maximal assistance with toileting hygiene and shower/bathe self. A review of Resident 1's Care Plan for Potential to be physically aggressive related to anger, initiated 12/16/25, indicated the goal was that Resident 1 will not harm self or others. The Care Plan goal indicated to monitor, and document observed behavior and attempted interventions in behavior logs. During a review of Resident 1's Situation, Background, Assessment, and Recommendation (SBAR) Communication Form and Progress Note, dated 12/21/2025, the SBAR indicated Resident 1 was agitated and confused. The SBAR indicated Certified Nursing Assistant (CNA) 1 heard arguing coming from Resident 1's room (room [ROOM NUMBER]). When CNA 1 arrived at room [ROOM NUMBER], Resident 2 stated Resident 1 threatened to hit Resident 2 with Resident 2's slipper. During a review of Resident 1's Progress Note (PN), dated 12/21/2025 at 6:46 PM, the PN indicated CNA 1 heard noise coming from room [ROOM NUMBER]. The PN indicated Resident 2 stated that Resident 1 threatened to use Resident 1's slipper to hit Resident 2. The PN indicated the incident was reported to the Director of Nursing (DON) and the Administrator (ADM). During a review of Resident 1's Interdisciplinary Team (IDT) Conference, dated 12/22/2025, the IDT Conference indicated Resident 2 stated that Resident 1 was waving a slipper in Resident 2's face, and stated that Resident 2 was in Resident 1's bed. Resident 1 stated Resident 2 would hit Resident 1 if Resident 1 did not get out the bed. The IDT indicated a room change was conducted and Resident 1 was moved to room [ROOM NUMBER] During a review of Resident 2's AR, the AR indicated the facility originally admitted Resident 2 on 9/17/2024 and readmitted on [DATE] with diagnoses that included major depressive disorder (a serious mood disorder causing persistent sadness, loss of interest, and significant impairment in daily life) and hypertension (high blood pressure). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had severely impaired cognition and memory. The MDS also indicated Resident 2 required setup or clean-up assistance with eating, partial/moderate assistance with oral hygiene, substantial/maximal assistance with personal hygiene, and was dependent with chair/bed-to-chair transfer, and with toileting hygiene and shower/bathe self. During a review of Resident 2's SBAR, dated 12/21/2025, the SBAR indicated Resident 2 reported that Resident 1 was confused and thought Resident 2 was in her bed and waved a slipper at Resident 2 and told Resident 2 to get off from the bed. During an interview on 12/26/2025 at 11:13 AM with Resident 2, Resident 2 stated Resident 1 was her room [room [ROOM NUMBER]] when the incident on 12/21/25 occurred. Resident 2 stated she was lying in her bed and Resident 1 started yelling angerly at Resident 2 and stated that Resident 2 was lying in Resident 1's bed. Resident 1 told Resident 2 to get out of her bed. Resident 2 stated Resident 1 had a slipper in her hand and threatened to hit Resident 2. Resident 2 stated she yelled Stop, Stop. Resident 2 stated the incident was scary for her. Resident 2 stated Resident 1 was reassigned to a different room. During an interview on 12/26/2025 at 11:24 AM with CNA 1, CNA 1 stated on 12/21/2025 around 5 PM, she was in the hallway across from room [ROOM NUMBER] and heard Resident 2 yelling Stop, stop and saw Resident 1 walking out from room [ROOM NUMBER]. CNA 1 stated Resident 2 reported Resident 1 was trying to hit her. During an interview on 12/26/2025 at 12:05 PM with