

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/13/2026
NAME OF PROVIDER OR SUPPLIER  Temple City Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0555</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to choose his or her attending physician.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on an interview and record review, the facility failed to ensure that a resident was allowed to exercise the right to choose a physician for one of two sampled residents (Resident 1) reviewed for residents' rights. The facility did not work with Resident 1 to select another physician of the resident's preference when the current attending physician (Physician 1) was unable to provide the necessary care and services before transferring care to an alternate physician (Physician 2). This deficient practice had the potential to prevent Resident 1's preferences from being honored. During a record review of Resident 1's admission Record (AR), dated 12/20/2025, the AR indicated Resident 1 was admitted to the facility on [DATE] with medical diagnoses that included Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), ESRD (End Stage Renal Disease-irreversible kidney failure) with hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/25/2025, the MDS indicated that Resident 1's cognitive skills (related to thinking, reasoning, decision making and problem solving) were cognitively intact. The MDS further indicated Resident 1 required substantial/maximal assistance on staff for shower/bathe self and putting on and off footwear. Partial/moderate assistance for lower body dressing, upper body dressing, and toileting hygiene. During a concurrent interview and record review on 1/13/2026 of Resident 1's Order Summary Report dated 1/2/2026, the report indicated transfer of care from Physician 1 to Physician 2. The Director of Nursing (DON) stated the attending physician (Physician 1) was not responding to the facility and pharmacy staff calls for the care of Resident 1. The DON stated this was communicated to the Medical Director (Physician 2) who took over the care of Resident 1. During an interview on 1/13/2026 at 4:11 PM with the DON, the DON stated that Resident 1 was made aware of the change of physician but was not involved in choosing the physician. DON stated that it is important for the resident to be involved in the plan of care and in choosing attending physicians to make sure it aligns with the resident values and wishes as well as to respect the residents' rights. During a review of the facility's policy and procedure, titled Informed Consents, dated 12/2018, indicated that it is the policy of the facility to uphold the rights and dignity of the residents, including the right to make informed decision about their care. During a review of the facility's policy and procedure, titled Physician Services, dated 6/2022, indicated that the physician supervises the medical care of residents by means of participating in the resident's assessment and care planning monitoring changes in residents medical status and providing consultation or treatment when contacted by the facility it includes prescribed medications.</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056413
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to administered medication Lyrica (a medication that treats nerve pain) as ordered for neuropathy (disease or dysfunction of one or more nerves, typically causing numbness, tingling, burning pain in the hands and feet) for one of two sampled residents (Resident 1) as ordered by the attending physician. This deficient practice resulted in the resident missing the medication as scheduled and could result in increased discomfort. During a record review of Resident 1's admission Record (AR), dated 12/20/2025, the AR indicated Resident 1 was admitted to the facility on [DATE] with medical diagnoses that included Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), ESRD (End Stage Renal Disease-irreversible kidney failure) with hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/25/2025, the MDS indicated that Resident 1's cognitive skills (related to thinking, reasoning, decision making and problem solving) were cognitively intact. The MDS further indicated Resident 1 required substantial/maximal assistance on staff for shower/bathe self and putting on and off footwear. Partial/moderate assistance for lower body dressing, upper body dressing, and toileting hygiene. During a record review of Resident 1's Order Summary Report dated 12/20/2025, the report indicated a physician order for Lyrica 150 mg milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) give 1 capsule by mouth three times a day for neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet). During a concurrent interview and record review on 1/13/2026 of Resident 1's Order Summary Report dated 1/2/2026, the report indicated transfer of care from Physician 1 to Physician 2. The Director of Nursing (DON) stated the attending physician (Physician 1) was not responding to the facility and pharmacy staff calls for the care of Resident 1. The DON stated this was communicated to the Medical Director (Physician 2) who took over the care of Resident 1. During a concurrent interview and record review on 1/13/2026 at 12:10 PM with the Director of Nurses (DON), the Medication Administration Record (MAR), dated 12/01/2025 - 12/31/2025, and 1/1/2026 - 1/31/2026 was reviewed. The MAR indicated that Lyrica was not administered due to it being unavailable from the pharmacy. The DON stated that the facility's pharmacy had faxed a Request for New/Continuance of Schedule II-V Medication Therapy authorization to the facility and to the physician, but the attending physician did not respond to the pharmacy or the facility. The DON stated that the physician was not responding and could not provide services to Resident 1. The facility's medical director was then made aware and took over the care of Resident 1. During an interview with the Registered Pharmacist (RP) on 1/14/2026 at 10:27 AM the RP stated that on 12/22/2025 the pharmacy faxed a Request for New/Continuance of Schedule II-V Medication Therapy authorization for approval to the facility and to the physician. The authorization was not received by the physician. On 1/2/2026 the Request for New/Continuance of Schedule II-V Medication Therapy authorization approval was re-sent to the facility and the attending physician but was not received. RP stated that the pharmacy was not made aware of Resident 1's change of physician on 1/2/2026. RP stated on 1/8/2026 the pharmacy finally received the authorization approval for Lyrica from the physician. During an interview on 1/13/2026 at 4:11 PM with the Director of Nursing (DON), stated that it is important to administer medications as ordered by the physician to prevent relapse of conditions or withdrawal symptoms depending on the medication. During a review of the facility's policy and procedure (P&amp;P) titled, Medication Therapy, dated 12/2017, The P&amp;P indicated, shortly after</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>admission of a resident the staff and the practitioner assisted by the consultant pharmacist will review the current medication regimen. During a review of the facility's policy and procedure (P&amp;P) titled, Physician Services, dated 6/2022, the P&amp;P indicated, the facility must ensure that the medical care of each resident is supervised by a physician and to ensure that another physician supervises the medical care of residents when their attending physician is unavailable.</p>		