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	02/06/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure (Resident 1) who received psychotropic (medications to manage mood, behavior, or perception) was free of unnecessary chemical restraints. This deficient practice had the potential to result in Resident 1 receiving unnecessary medication and can lead to adverse medication reactions. During a review of Resident 1's admission Record (AR) indicated Resident 1 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses of unspecified dementia (a progressive state of decline in mental abilities), difficulty in walking, Non-Hodgkin lymphoma (NHL - is?a type of blood cancer that develops in the lymphatic system). During a review of Resident 1's History and Physical (H&P), dated 8/8/2025, the H&P indicated Resident 1 was admitted from the General Acute Care Hospital (GAHC) with diagnosis of recurrent falls. During a review of Resident 1's History and Physical (H&P), dated 11/15/2025, the H&P indicated Resident 1 does not have the mental capacity to understand and make medical decisions. During a review of Resident 1's Medication Administration Record (MAR), dated 12/1/2025 - 12/31/2025, 1/1/2026 -1/31/2026, the MAR indicated Resident 1 was receiving: Duloxetine (antidepressant medication) 60 milligrams (mg - metric unit of measurement, used for mediation dosage and/or amount). once a day for depression manifested by crying. Clonazepam (Benzodiazepine for severe anxiety medication) 0.5 mg every 12 hours for anxiety manifested by yelling and crying. Depakote (mood stabilizer for bipolar mania medication) 250 mg two times a day for irritation and mood stabilization. Seroquel (antipsychotic medication) 100 mg two times a day for schizophrenia manifested by aggressive anger Lorazepam (Benzodiazepine/anti-anxiety) 0.5 mg every 6 hours as needed for anxiety manifested by yelling and screaming ordered on 12/11/25 x 14 days increased to 1mg on 12/14/2025 x 14 days. During a review of Resident 1's Psychiatric Evaluation, dated 12/8/2025, the Psychiatric Evaluation indicated Resident 1 was still delusional that people are in her room. During a review of Resident 1's Interdisciplinary Care Conference (IDT), quarterly dated 12/9/2025, the IDT indicated no medication review. During a review of Resident 1's Psychiatric Evaluation, dated 1/2/2026, the Psychiatric Evaluation indicated Resident 1 was still delusional that people are in her room. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 1/20/2026, the MDS indicated Resident 1 had a Brief Interview for Mental Status (BIMS - a tool used to screen and identify the cognitive condition) score of 5 which indicated to be severely impaired (problems with thinking/memory). The MDS also indicated that Resident 1 was dependent on shower/bathe self. Substantial/maximal assistance needed for oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, walking 10 feet. During a review of Resident 1's IDT with the admission dated 1/30/2026, the IDT indicated no medication review. During an interview on 2/4/2026 at 2:54 PM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated that Resident 1 is being monitored for crying, yelling, anger, resisting care. LVN 2 stated Resident 1 would get upset because Resident 1 wanted to go home. No (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	episodes of delusion that people are in her room are currently being monitored. LVN 2 stated that the purpose of monitoring episodes for why medications are being administered was to work on medication reduction. During a concurrent interview and record review on 2/4/2026 at 2:54 PM with LVN 2, Resident 2's MAR, dated 2/1/2026 - 2/4/2026 was reviewed. The MAR indicated that Resident 1 was receiving the following medications: 1. Duloxetine 60 mg once a day for depression manifested by crying. 2. Clonazepam 0.5 mg every 12 hours for anxiety manifested by yelling and crying. 3. Depakote 250 mg two times a day for irritation and mood stabilization. 4. Seroquel 100 mg two times a day for schizophrenia manifested by aggressive anger. 5. Lorazepam (Benzodiazepine/anti-anxiety) 0.5 mg two tablets every 6 hours as needed for anxiety manifested by yelling and screaming. LVN 2 stated the behavior for each of the medications including monitoring for side effects such as tardive dyskinesia, cognitive impairment, akathisia, parkinsonism, was not currently being monitored. During an interview on 2/4/2026 at 3:30 PM with Registered Nurse (RN) 1, RN 1 stated that Resident 1 needs Lorazepam (Ativan) for getting out of bed by herself and crying. RN 1 stated that she tried to stay with Resident 1, but RN 1 must complete her other duties and could not spend all the time with Resident 1. RN 1 stated there is no documentation of alternatives being used prior to administering anti-anxiety medication Lorazepam (20 times from 12/1/25 - 12/31/25, administered 13 times from 1/1/26 - 1/31/26). During a concurrent record review and interview on 2/4/2026 at 3:30 PM with RN 1, License Nurses Notes, dated 12/14/2025 at 7:20 AM, the notes indicated resident was being monitored for change of condition for inability to sleep and getting out of from the chair and roaming the psychiatrist. RN 1 stated Resident 1's Physician was called on 12/14/2025 and the Physician ordered to increase Lorazepam to 1 mg. RN 1 stated there were no alternatives documented prior to administering the PRN medication when administered 20 times from 12/1/25 - 12/31/25, administered 13 times from 1/1/26 - 1/31/26. During a review of the facility's policy and procedure (P&P) titled, Psychoactive Medication Management, dated 7/2017, the P&P indicated the residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience. During a concurrent interview with the Minimum Data Set Coordinator (MDSC) on 2/5/2025 at 10:00 AM and a review of the P&P titled, Psychoactive Medication Management, dated 7/2017, the P&P indicated IDT will review conduct the review of the response to psychoactive medication management at least quarterly and as needed. The P&P indicated the review to include recommendations for the continued usage, dose reduction, or discontinuation of medication. The MDSC stated, This was not done during quarterly meeting and when Resident 1 had a fall on 12/28/2025, 1/7/2026, 1/12/2026, and 1/21/2026.

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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** Based on observation, interview, and record review the facility failed to ensure that one of two sampled residents (Resident 1) reviewed for accidents and supervision, was free of accident hazards as possible by failing to identify the potential risk factors that led to resident falling on 12/28/2025, 1/7/2026, 1/12/2026, and 1/21/2026. Furthermore, the facility failed to ensure the Care Plan was revised after Resident 1 sustained a fall on 12/28/2025. As a result, Resident 1 fell again on 1/7/2026 and sustained an open cut to the bridge of the nose with bruising.These deficient practices resulted in Resident 1 sustaining a left hip fracture on 1/21/2026 [fourth fall] after falling from standing position and was transferred to General Acute Care Hospital (GACH) on 1/21/2026. On 1/23/2026, Resident 1 underwent surgery for a left hip hemi-arthroplasty (a surgical procedure that involves replacing half of the hip joint) and diminished in Activities of Daily Living (ADL) that included a decline from walking 10 feet to not walking anymore after Resident 1 was readmitted back to the facility on 1/29/2026. Resident 1 was transferred to a General Acute Care Hospital (GACH) for further evaluation and treatment. Findings: Findings: During a review of Resident 1's History and Physical (H&P), dated 7/23/2025, the H&P indicated Resident 1 lived at an assisted living facility and had multiple falls over the course of two weeks with 3-4 emergency room visits. The assisted living facility staff asked the General Acute Hospital's Case Manager to assist in placing Resident 1 in a skilled nursing facility. Resident 1 was admitted to the facility on [DATE]. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses of unspecified dementia (a progressive state of decline in mental abilities), difficulty in walking, Non-Hodgkin lymphoma (NHL - is a type of blood cancer that develops in the lymphatic system). During a review of Resident 1's Care Plan, titled High Risk for Falls Care Plan, dated 10/17/2025, indicated Resident 1 was at risk for falls due to confusion, gait/balance problem, psychoactive drug use, unaware of safety needs. The goal indicated for Resident 1 will be free of falls, free of minor injury, serious injury, resident's fall risk will be reduced. The Care Plan Interventions included anticipating, meeting Resident 1's needs, and following facility fall protocol. During a review of Resident 1's History and Physical (H&P), dated 11/15/2025, the H&P indicated Resident 1 does not have the mental capacity to understand and make medical decisions. During a review of Resident 1's Morse Fall Scale (MFS - a fall prevention evaluation that is a quick and efficient way to assess the risk factors of a patient falling) dated 12/3/2025 the MFS indicated Resident 1's score was105-high risk. During a review of Resident 1's Post Fall Assessment, dated 12/28/2025, the Post Fall Assessment indicated Resident 1 fell when attempting to get out of bed to go to the bathroom. Resident 1 was assessed with no apparent injury and was assisted to the bathroom after the fall. Further review of Resident 1's Care Plan, tilted High Risk for Falls Care Plan, indicated no new interventions were added to the care plan after Resident 1 fell on [DATE]. During a review of Resident 1's Post Fall Assessment, dated 1/7/2026, the Post Fall Assessment indicated Resident 1 slipped when Resident 1 attempted to get up to use the bathroom. During a record review of Resident 1's Progress Notes (PN), dated 1/7/2026 at 3:48 AM the PN indicated Resident 1 had an injury with the fall and sustained an open cut to the bridge of the nose with bruising. During a record review of Resident 1's PN, dated 1/7/2026 at 8:22 AM, the PN indicated the attending physician ordered Resident 1 to be sent out to the GACH. During a record review of Resident 1's PH, dated 1/7/2026 at 9:22 AM, the PN indicated Resident 1 was transferred to the GACH. During a record review on Resident 1's Progress Notes, dated 1/7/2026 at 5:40 PM Resident 1 was readmitted to the facility with laceration to the bridge (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the nose repaired with Dermabond (a sterile super glue used by doctors to close cuts, scrapes, or surgical incisions instead of using stitches, staples or tape) and Urinary Tract Infection (UTI - an infection in the bladder/urinary tract). UTI treated with Ceftriaxone (antibiotic) at the GACH and to continue Cefpodoxime (antibiotic) at the facility. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 1/20/2026, the MDS indicated Resident 1 was severely impaired (problems with thinking/memory) in cognition. The MDS also indicated that Resident 1 was dependent on shower/bathe self and needed substantial/maximal assistance for oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, and walking 10 feet. During an interview on 1/30/2026 at 1:07 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 never calls for help and that was her (Resident 1's) biggest issue. LVN 1 stated that Resident 1 would get out of bed and put her shoes on and get up without calling for staff assistance. LVN 1 further stated that at night Resident 1 gets up to try to use the bathroom without calling for staff assistance. LVN 1 stated that during the daytime there are more staff that can constantly watch Resident 1. During an interview on 1/30/2026 at 1:44 PM with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 1, always tried to get up without telling anyone and thinks she can still move normally, but she is weak. During an interview on 2/4/2026 at 3:11 PM with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 1 was not aggressive towards others and verbalized wanting to go home and cried one to two times a month. During an interview on 2/5/2026 at 1:39PM with the DON, DON stated Resident 1 can use the call light but chooses not to use the call light because Resident 1 does not want assistance. The DON stated that the intervention for frequent visual checks was not entered on Resident 1's care plan. DON stated it should have been entered into the care plan, but it was not done. During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Plan of Care, dated 12/2016, indicated care plans must be re-evaluated and modify to reflect changes in care quarterly and with significant change in status.