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	03/16/2025

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on observation, interview and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect in full recognition of her individuality for one out of the 13 sampled residents (Resident 27) who was observed being assisted by a facility staff who standing over and not at the eye level of the resident while assisting her during a meal. This deficient practice had the potential to affect Resident 27's self-esteem, self-worth, and the resident's sense of independence Findings: During a review of Resident 27's Admission Record (Face Sheet), the facility admitted Resident 27 on 10/5/2018, and readmitted on [DATE] with diagnoses including diabetes mellitus (DM: long-term metabolic disorder that is characterized by high blood sugar, insulin resistance, and relative lack of insulin) and hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated). During a review of Resident 27's History and Physical (H&P), dated 12/21/2024 indicated, Resident 27 had fluctuating capacity to understand and make decisions. During a review of Resident 27's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 2/20/2025, indicated the cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and required moderate assistance with eating. During a meal observation on 3/15/2025 at 12:15 PM, in the Dining Room, Resident 27 was observed seated on a wheelchair. Certified Nursing Assistant 1 (CNA 1) was observed standing while feeding lunch to Resident 27. During an interview with the Director of Nursing (DON) on 3/16/2025 at 8:58 PM, the DON stated staff should sit down while feeding residents. During a review of the facility's policy and procedure (P&P) titled, Assistance with Meals, indicated residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example, not standing over residents while assisting them with meals.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on observation, interview, and record review, the facility failed to accommodate the needs two of three sampled residents (Resident 1 and Resident 12) by ensuring the resident's call lights (a device used to alert staff to the resident ' s room) were placed within the resident reach in accordance with the facility's policy and procedure [P&P] titled Answering Call lights. This deficient practice had the potential for the residents not to receive care and services that could result in accidents and falls. Findings: 1. During a review of Resident 1's Admission Record (AR), the AR indicated the resident was originally admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses that included Parkinson ' s Disease without Dyskinesia (a disorder of the central nervous system that affects movement, often including tremors), Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). During a review of Resident 1's History and Physical (H&P), dated 11/24/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/21/2024, the MDS indicated the resident had severe cognitive impairment skills for decision making. During a review of Resident 1's care plan for falls, initiated on 7/19/2019 , the care plan indicated Resident 1 was at risk for falls. The care plan included interventions for staff to place the resident's call light within reach and answer promptly. 2. During a review of Resident 12's AR, the AR indicated the resident was originally admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses that included Type 2 Diabetes Mellitus, unspecified dementia (a disease that affect your thinking, memory, reasoning, personality, mood and behavior). During a review of Resident 1's H&P, dated 11/14/2024, the H&P indicated Resident 12 did not have the capacity to understand and make decisions. During a review of Resident 12's MDS, dated [DATE], the MDS indicated the resident had severe cognitive impairment skills for decision making. During a review of Resident 12's care plan for falls, initiated on 3/20/2023 and revised 3/16/2025 , the care plan indicated Resident 1 was at risk for falls. The care plan included interventions for staff to place the resident's call light within reach and answer promptly. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation in Resident 1 and 12's room on 3/14/2025 at 7:55 PM, Resident 1 and 12 ' s call lights was observed stored inside the resident ' s personal belongings drawer next to the resident ' s bed. During a concurrent observation and interview in Resident 1 and 12' s room on 3/14/2025 at 7:58 PM, the DON stated call lights should be within resident ' s reach and should not be in the drawers. The call lights should be within reach in case the residents needed assistance. During a concurrent record review and interview the DON on 3/15/2025 at 9:00 AM, DON stated Resident 1 and 12 have a behavior of putting their call light in their drawers. DON stated she would be updating resident 1 and 12' s fall care plan' s and interventions to reflect the behaviors and ensure the residents had appropriate interventions. During a review of the facility's policy and procedure (P&P) titled Answering call lights dated August 2017, indicated The purpose of this procedure is to respond to the residents request and needs .The policy further indicated Ensure call lights are plugged in at all times. When a resident is in bed and confined to chair the call light will be placed within reach.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on interview and record review, the facility failed to inform and provide written information for one (1) of 1 sampled resident (Resident 4) regarding their right to be informed and signed a written consent about the medication's use and side effects (undesired effect) before receiving Invega Sustenna (medication to treat schizophrenia [disorder that affects a person ' s ability to think, feel, and behave clearly]) that was not dispensed from facility ' s pharmacy. This deficient practice resulted in Resident 4's violation of residents right and received Invega Sustenna and experience side effects that could lead to a decline in the resident ' s well being. Findings: During a review of Resident 4's Admission Record indicated an admission on 12/11/2024 with diagnoses of Parkinson's disease (a disorder of the central nervous system that affects movement, often tremors), encephalopathy (a change in how your brain functions), and muscle weakness. During a review of Resident 4's History and Physical assessment dated [DATE], indicated Resident 4 had fluctuating capacity to understand and make decisions. During a review of Resident 4's Order Summary dated 12/11/2024 indicated a physician order for Invega Sustenna (medication to treat schizophrenia [disorder that affects a person ' s ability to think, feel, and behave clearly] and schizoaffective disorder [mental health condition including schizophrenia and mood disorder symptoms]) Intramuscular (injected into the muscle) suspension prefilled syringe 234 milligram (mg, unit of measure) per 1.5 milliliters (ml, unit of measure) inject 234 mg intramuscularly one time a day starting on the 18th and ending on the 18th every month for schizophrenia manifested by hearing voices and talking to self. During a telephone interview on 3/16/2025 at 1:44 PM, Licensed Vocational Nurse (LVN) 3 stated she was given sample medication of Invega from the former Director of Nursing (DON) to give to Resident 4. LVN 3 stated she and LVN 5 were both asked to administer the sample Invega because pharmacy did not deliver medication to the facility. During a telephone interview on 3/16/2025 at 3:15 PM, LVN 5 stated the facility ' s former DON gave LVN 5 a sample medication of Invega Sustenna for Resident 4 before and on 1/18/2025 Resident 4 ' s Invega medication was not available at facility During a telephone interview on 3/16/2024 at 3:43 PM, the pharmacist ([NAME]) stated Resident 4 ' s Invega Sustenna was delivered to the facility on [DATE] and 2/19/2025. The [NAME] stated she did not see a delivery for Resident 4 ' s Invega for the months of 12/2024 and 1/2025. During an interview with the DON on 3/16/2025 at 4:07 PM, the DON stated Resident 4 ' s physician provided the Invega medication. The DON stated she could not recall any other details as it was a different DON at the time. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator (ADM) on 3/16/2025 at 8:53 PM, the ADM stated Resident 4 was given sample medication of Invega but unsure if staff received Resident 4 ' s consent or if the resident was instructed about Invega Sustenna before administering sample Invega medication. A review of Resident 4's clinical record had no documented evidence a consent was obtained from the resident, or if instructions were provided to the resident about the side effects of the medication. During a review of the facility's undated policy and procedures (P&P) titled Medication Administration indicated the purpose was to assure the most complete and accurate implementation of physician's medication orders and to optimize drug therapy for each resident by providing for administration of drugs in an accurate, safe, timely, and sanitary manner.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on interview and record review, the facility failed to complete the Notification of bed-hold and Return form (a form that indicates the resident's rights to return to the facility after hospitalization) for one of two sampled residents (Resident 29) who was transferred to the General Acute Care Hospital (GACH) in accordance with the facility's policy and procedures. This deficient practice resulted in the violation of the resident's rights to be informed about the Notification of bed-hold and Return policy and to be aware that the resident can return to the facility after hospitalization as ordered by the physician. Findings: 1. During a review of Resident 29 ' s Admission Record (Face Sheet), the facility admitted Resident 29 on 1/9/2025, and readmitted on [DATE] with diagnoses diabetes mellitus (DM: long-term metabolic disorder that is characterized by high blood sugar, insulin resistance, and relative lack of insulin) and hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated) During a review of Resident 29 ' s History and Physical (H&P), dated 1/11/2025 indicated, Resident 29 had the mental capacity to make medical decisions. During a review of Resident 29's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 1/22/2025, indicated the resident ' s cognitive (the ability to think and process information) skills for daily decisions making) was intact, and, and required limited assistance of one-person physical assist for activities of daily living. During a review of Resident 29 ' s SBAR (Situation, Background, Assessment, Recommendation) is a communication tool used to structure conversations, especially in healthcare, to ensure efficient and accurate information transfer, particularly during critical situations) Communication Form and progress note form, dated 2/17/2025, indicated that the resident had red color urine, pain level 5-6/10. A review of Resident 29's clinical record on 3/16/20245 at 3:20 PM with Medical Records and she stated that there was no Notification of bed-hold and Return when the resident transferred to GACH on 2/17/2025. During an interview on 3/16/2025 at 8:20 PM with the Director of Nursing (DON), the DON stated Resident 29's the bed hold notification form should have been acknowledged, signed by either the resident or responsible party, and the bed hold is good for seven days. During a review of the facility's policy and procedure (P&P) titled, Bed-Hold, indicated The facility provides written notification to all residents, family members and/or legal representative of the bed/hold policy upon admission, and at the time of transfer, in accordance with federal and state guidelines.

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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** 42854 Based on interview and record review the facility failed to develop a resident specific care plan that included interventions to monitor for the side effects such as bruising and bleeding for the use of Apixaban (a medication that thins blood or an anticoagulant medication) used to treat and prevent blood clots) for DVT (deep vein thrombosis - a blood clot that blocks the flow of blood in the veins) for one of one sampled residents (Resident 35) prophylaxis (prevention). This deficient practice had the potential for the staff not to be able to provide care needed by the resident who was at risk for bleeding to develop bleeding in the body that could lead to excessive bleeding and blood loss resulting to death. Findings: During a review of Resident 35's Admission Record indicated a readmission to the facility on [DATE] with diagnoses that included encounter for palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), hypertension (high blood pressure). During a review of Resident 35's History and Physical assessment dated [DATE] indicated Resident 35 lacked decision-making capacity. During a review of Resident 35's Order Summary Report dated 12/31/2024 indicated a physician order for Apixaban Oral Tablet 2.5 milligrams (mg, unit of measure) to be given one tablet by mouth two times a day for DVT prophylaxis. During a concurrent interview and record review of Resident 35's care plans on 3/16/2025 at 7:45 PM, with the Director of Nursing (DON), the DON stated she could not find documented evidence of a care plan that indicated how Resident 35 was to be monitored for the use of Apixaban when it was ordered by physician on 12/31/2024. The DON stated the care plan for Apixaban should have been started when resident was admitted . The DON stated the purpose of initiating a care plan for Apixaban at the time it was first ordered was to have interventions and care instructions of what staff should do to help the resident with the problem. The DON stated the importance of an Apixaban care plan was to monitor side effect of bleeding and to notify the physician. A review of the facility's policy and procedure titled Comprehensive Plan of Care, dated 12/2016 indicated the comprehensive care plan must describe services that are provided to the resident to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being that will accommodate resident needs, request and refusal to treatment. The P&P indicated comprehensive care plans will be fully developed within 7 days after completed the comprehensive assessment. The P&P indicated to ensure that care plan entries are signed and dated as they occur and that interventions specify the frequency of service provided.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 42878 Based on interview and record review, the facility failed to ensure one out of three sampled Licensed Vocational Nurses (LVN 2) and two out of three sampled Certified Nursing Assistants (CNA 3) had adequate competency and skill sets by ensuring the staffs completed the annual competency assessment and evaluation (a process that assess and evaluates an employees skills, knowledge and performance) for the appropriate job category when providing quality care. As a result of this deficient practice the residents had the potential not to receive quality of care under the standard of practice which could lead to a decline in the resident's wellbeing. Findings: During a review of LVN ' s 2 employee file records indicated the facility hired LVN 2 on 6/1/2012. LVN 2 ' s employee records included a Licensed Nurse Master competency Evaluation Worksheet undated. The section titled validators assessment was left blank indicating LVN 2 was not evaluated for skills and competency. During a review of CNA ' s 2 employee file records indicated the facility hired CNA 2/2/2021. CNA ' s 3 employee records included a Certified Nursing Assistant Master Competency Check List dated 2/16/2023. The section titled validators assessment was left blank indicating CNA 1 was not evaluated for skills and competency. During a review of CNA ' s 3 employee file records indicated the facility hired CNA 8/09/2021. CNA ' s 3 employee records included a Certified Nursing Assistant Master Competency Check List dated 2/17/2023. The section titled validators assessment was left blank indicating CNA 3 was not evaluated for skills and competency. During an interview and concurrent record review on 3/16/2025 at 8:03 AM with Director of Staff Development (DSD), DSD stated Competency evaluation are conducted via written test and return demonstration upon hiring and annually for all staff. The DSD stated she did not know why CNA 2 and CNA3 ' s annual competency was not completed in 2024. During an interview and concurrent record review on 3/16/2025 at 10:27AM with the Director of Nursing (DON), the DON stated all Licensed Nurses should complete competency skills upon hire and then annually. The DON stated she did not know why LVN 2 ' s annual competency was not completed last year. During a review of facility ' s policy and procedure titled, Competency Evaluation dated with revision date of July 2019, indicated It is the facility ' s policy to performance competency evaluations for all employees annually each employee ' s competency will be reviewed during the performance evaluation review

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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** 42854 Based on interview and record review, the facility failed to prevent unnecessary use of medication by ensuring one of one sampled resident (Resident 25) was monitored for bruising and bleeding while receiving Apixaban (a medication used to thin the blood and to treat or prevent deep venous thrombosis [DVT, a condition in which harmful blood clots form in the blood vessels of the legs]). This deficient practice increased the risk of Resident 35 to experience adverse effects (unwanted and dangerous side effects of medication) that could lead to health complications, such as excessive bleeding in the intestines and stomach or other parts of the body, bruising that could lead to death. Findings: During a review of Resident 35 ' s Admission Record indicated a readmission to the facility on [DATE] with diagnoses that included encounter for palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), hypertension (high blood pressure). A review of Resident 35 ' s History and Physical assessment dated [DATE] indicated Resident 35 lacked decision-making capacity. A review of Resident 35 ' s Order Summary Report indicated a physician order for the following: On 12/31/2024, a physician order for Apixaban Oral Tablet 2.5 milligrams (mg, unit of measure) give 1 tablet by mouth two times a day for DVT prophylaxis. On 1/12/2025, a physician order to monitor for bleeding code (-) if not present, (+) if present for Apixaban use every shift, notify MD if bleeding. During a review of Resident 35 ' s Medication Administration Record (MAR) dated 1/2025 indicated Resident 35 received Apixaban on the following days: 1/2/2025 to 1/21/2025 and 1/29/2025 to 1/31/2025. The MAR indicated no monitoring for bleeding or bruising or any other side effects of Apixaban was documented on 1/2/2025 to 1/12/2025 and 1/29/2025 to 1/31/2025. During a concurrent interview and record review of Resident 35 ' s MAR on 3/16/2025 at 7:45 PM, the Director of Nursing (DON) stated she could not find documented evidence in the MAR during 1/2/2025 to 1/12/2025 and 1/29/2025 to 1/31/2025, that licensed nurses monitored Resident 35 for bleeding or side effects of Apixaban. The DON stated when resident is using Apixaban, licensed nurses should monitor for side effects of bleeding and notify the physician if there was any bleeding. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled Anticoagulation Therapy Management dated 7/2017 indicated the facility ensures that anticoagulants are given as ordered and monitored as ordered by physicians. The P&P indicated throughout anticoagulant therapy, monitor the resident for signs and symptoms of bleeding, if signs and symptoms of bleeding are noted, hold anticoagulant medication and notify physician immediately.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview, and record review, the facility failed ensure drugs and biologicals used in the facility were labeled and stored in accordance with currently accepted professional principles, and include the appropriate dosage and length of therapy by failing to ensure: 1. Resident 4's medications were labeled correctly. Resident 4 was ordered by the physician o receive Depakote (also known as Divalproex Sodium medication to treat seizures and bipolar disorder [mental health condition that causes extreme mood swings]) ER (Extended Release, medications designed to make them last longer in the body). The bubble pack (a card that packages doses of medication within small, clear, or light-resistant amber-colored plastic) was labeled Divalproex Sodium DR (delayed release-a type of medication designed to release active ingredients slower rate in the gastrointestinal tract). 2. The Curad triple antibiotic ointment (ointment used to treat infection) and antibiotic Stomahesive protective powder (powder that absorb moisture and protect skin from damage) stored in the medication storage. This deficient practice had the potential harm to residents due to the potential loss of strength of the medications, and the potential for the resident to receive ineffective medication dosages. Findings: 1. During a review of Resident 4 ' s Admission Record indicated an admission on [DATE] with diagnoses of Parkinson ' s disease (a disorder of the central nervous system that affects movement, often tremors), encephalopathy (a change in how your brain functions), and muscle weakness. During a review of Resident 4 ' s History and Physical assessment dated [DATE], indicated Resident 4 had fluctuating capacity to understand and make decisions. During a review of Resident 4's Order Summary, physician order dated [DATE], indicated Depakote (also known as Divalproex Sodium medication to treat seizures and bipolar disorder [mental health condition that causes extreme mood swings]) ER (Extended Release, medications designed to make them last longer in the body) oral (by mouth) tablet ER 24 hour 250 mg give 3 tablets two times a day for bipolar (extreme mood changes) manifested by poor impulse control. During a concurrent observation, interview and record review of Resident 4 ' s Medication Administration Record (MAR) with Licensed Vocational Nurse (LVN) 4 on [DATE] at 10:05 AM, LVN 4 compared Resident 4 ' s medications in the physician order and in the MAR. LVN 4 stated Resident 4 ' s bubble pack label for Depakote (Divalproex) did not match the physician ' s order on the MAR. The bubble pack label for Depakote indicated Divalproex Sodium DR (delayed release) 250 mg tablet, give 3 tablets by mouth two times a day given for bipolar disorder. The bubble pack was observed with two (2) tablets out of fourteen (14) tablets of Depakote were empty. LVN 4 stated she would verify the order with the pharmacy and document on progress note. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:15 AM, LVN 4 stated it was important for the physician order and bubble pack prescription label to match to make sure that nurses were giving the right medication if ER or DR as ordered the physician. LVN 4 stated it was important to clarify if the order was for extended release or delayed release because giving the wrong dose might fluctuate the resident ' s behavior. During an interview with the Director of Nursing (DON) on [DATE] at 8:14 PM, the DON stated ER and DR were different medication doses and it was important to follow the physician ' s order. The DON stated nurses should notify the physician because the medication has different time release and might have different side effects. The DON stated nurses should verify the order with the physician and pharmacy. 2. During a concurrent observation of the house supply medication storage room for station 2 and interview with treatment nurse (TN) 1 on [DATE] at 9:34 AM, observed four unopened boxes of Curad triple antibiotic ointment with expiration of ,d+[DATE] and 2 Stomahesive protective powder polvo protector bottles with expiration of [DATE] in medication storage. TN 1 stated the expired medication and supplies should not be included in the house supply so that the staff does not use the medication. TN 1 stated the medication would not be as effective and the treatment nurse should always check for expiration date. During a review of the facility ' s policy and procedure (P&P) titled Medication Storage in the Facility dated , d+[DATE] indicated outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. During a review of the facility ' s undated P&P titled Medication Administration indicated the purpose was to assure the most complete and accurate implementation of physician ' s medications orders and to optimize drug therapy for each resident by providing administration of drugs in an accurate, safe, timely, and sanitary manner.

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

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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. 50012 Based on observation, interview, and record review, the facility failed to ensure the food were stored prepared and distributed of food under sanitary conditions and served food in accordance with professional standards for food service safety and the facility's policy and procedure for 47 of 47 residents in the facility by failing to: 1. Document in the Sanitization Bucket Log the concentration of Quaternary Ammonia solution(a solution used to kill germs and bacteria) parts per million (PPM) that indicates the solution concentration effectively eliminate disease causing organisms. 2. Document in the Dish Machine Cleaning Log the temperature of the water during dish washing, during rinse and sanitation concentration. 3. Ensure the kitchen trashcan remained closed as required to prevent contamination and maintained sanitary food preparation environment. These deficient practices placed the residents at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages) and increased the risk of pest infestation and cross-contamination affecting the health and safety of residents. Findings: 1. During an initial kitchen observation, record review and concurrent interview on 3/14/2025 at 6:15 PM with the [NAME] 1, the log for the month of March 2024 titled Sanitizer Bucket Log had missing entries that the cleaning solution Quaternary Ammonia was checked for ppm test results for 3/14/2024 from 9:30 AM to 5 PM. [NAME] 1 stated staff was supposed to fill out the log after each meal, after each use. [NAME] 1 verified that log entries were missing for the date mentioned above. [NAME] 1 stated the sanitizing bucket is used to sanitize the food preparation area to reduce the number of bacteria on non-food contact surfaces. On 3/14/2025 at 6:15 PM, during an initial tour of the kitchen with cook 1, the Record of Sanitizer Bucket Log was reviewed. The form had columns to enter the data seven times a day at 5:30 AM, 7:30 AM, 9:30 AM, 11:30 AM, 1PM, 3 PM, and 5 PM, however, there were many blank columns. The last entry on the record was at 7:30 AM, on 3/14/2025. During an interview with the Dietary Supervisor (DS) on 3/15/2025 at 11:50 AM, DS stated she was responsible making sure the log is filled out after each use of the test strip. When asked about the missing entries on the Record of Sanitizer bucket log. The DS stated that every staff member of the kitchen is responsible for completing the log. The DS stated he may have missed it. The DS stated he would follow up and make sure everyone follows through. The DS stated he would make sure the log is filled out accurately and consistently. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on 3/14/2024 at 6:20 PM, a review of the log for the month of March 2025 titled Dish Machine Log had missing entries with staff initials for 3/14/2025. [NAME] 1 stated staff is supposed to fill out the log daily. On 3/14/2025 at 6:15 PM, during an initial tour of the kitchen with cook 1, the Dish Machine Log was reviewed. The form had columns to enter the data three times a day at breakfast, Lunch and dinner. Data to be enter is the temperature of the water during dish washing, water temperature during rinse and sanitation concentration, however, there were many blank columns. The last entry on the record was at breakfast, on 3/14/2025. During a review of the facility's policy and procedure (P&P) titled, Ware washing Policy, indicated the temperature and/or sanitizer concentration logs will be completed, as appropriate. 3. During a concurrent observation and interview on 3/14/2025 at 6:20 PM during an initial kitchen tour with the [NAME] 1, the trashcan located in the food preparation area that contained food waste had a lid open. The trashcan remains opened during the initial kitchen tour, despite no active use, creating a potential risk for contamination and pest attraction. The cook 1 stated that trash can is required to be closed when not in used. During a review of the facility's policy and procedure (P&P) titled, Environment indicated all trash will be contained in covered, leak proof containers that prevent cross contamination.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on observation, interview, and record review, the facility failed to implement the facility's policy and procedure on infection control for three of 3 residents (Residents 13, 27 and 36) by failing to ensure: 1. Activity Assistant 1 (AS) and Certified Nursing Assistant (CNA) 4, performed hand hygiene while distributing resident meal trays to Resdent 13 and Resident 27. 2. Resident 36's nebulizer mask (mask used to deliver the liquid medication) was properly store when not in use to prevent contamination. These deficient practices had the potential to transmit infectious microorganisms and increase the risk of infection for the residents. Findings: 1.During a review of Resident 13's Admission Record (Face Sheet), the facility admitted Resident 13 on 10/8/2017 and readmitted on [DATE] with diagnoses including diabetes mellitus (DM: long-term metabolic disorder that is characterized by high blood sugar, insulin resistance, and relative lack of insulin) and hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated). During a review of Resident 13's Minimum Data Set (MDS-a federally mandated resident assessment tool.), dated 1/14/2025, indicated the cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and required moderate assistance for activities of daily living. During a review of Resident 27's Admission Record (Face Sheet), the facility admitted Resident 27 on 10/5/2018 and readmitted on [DATE] with diagnoses including diabetes mellitus (DM: long-term metabolic disorder that is characterized by high blood sugar, insulin resistance, and relative lack of insulin) and hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated). During a review of Resident 27's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 2/20/2025, indicated the cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and required moderate assistance with eating. During an observation on 3/15/2025, at 12:05 PM, Activity Assistant 1 (AS) 1 was observed obtaining a meal tray from the meal tray cart and assisted setting up tray for Resident 13 ' s . CNA 4 was observed setting up the meal tray for Resident 13. CNA 4 was then observed exiting Resident 13's room and then obtaining another meal tray from the meal tray cart for Resident 257. CNA 4 entered Resident 257 ' s room, CNA 4 was observed not performing hand hygiene in between meal tray distribution and set up for Resident 13 and Resident 257. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/15/2025 at 12:05 PM, the AS stated not performing hand hygiene in between assisting Resident 13 and 27. AS 1 stated she should have performed hand hygiene before and after entering or exiting any resident's room. AS 1 stated it was important to performed hand hygiene to prevent cross contamination between residents. During an interview on 3/16/2024 at 8:20 p.m. with the Director of Nursing (DON), the DON stated according to the facility's policy, all nursing staff were supposed to wash their hands prior to any physical contact or providing care and to wash their hands before and after the procedure. 42878 2. During a review of Resident 36's Admission Record (AR), the AR indicated the resident was originally admitted to the facility on [DATE] and then readmitted on [DATE], with diagnoses that included acute respiratory failure with hypoxia (oxygen deficiency), Type 2 diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). During a review of Resident 36's History and Physical (H&P), dated 2/05/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 36's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 3/10/2025, the MDS indicated the resident had moderate cognitive (thought process and ability to reason) impairment skills for decision making. During a review of Resident 36's Order Summary Report dated 3/16/2025 indicated a Physicians order for: Albuterol Sulfate Inhalation Nebulization Solution (a medications used for shortness of breath) 2.5 milligrams inhale orally via nebulizer three times a day for shortness of breath, with an order start date of 3/05/2025. During an observation on 3/14/2025 at 7:28 PM, Resident 36 ' s nebulizer mask was observed laying inside Resident 36 ' s personal belongings drawer next to his bed. During a concurrent interview and observation on 3/14/2025 at 7:29 PM of Resident 36 ' s room with Vocational Nurse 1 (LVN 1), LVN 1 stated she did not know why resident 1 ' s nebulizer was sitting inside resident 1 ' s personal belongings drawer but it should be kept inside a clear plastic bag when not in use to prevent it from being contaminated. During an interview on 3/16/2025 at 7:49 PM with Director of Nursing (DON), the DON stated all resident nebulizer breathing treatment mask should be stored properly inside clear plastic bag that is labeled when not in use. The DON stated it can make a resident sick if it ' s just left laying in the open as the mask can become contaminated. During a review of the facility ' s policy and procedure (P&P) titled Guidelines for changing of Disposable Respiratory Equipment dated August 2017, indicated hand held nebulizer-store in a public bag between uses, label bag with resident name, room number, and date changed.

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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** 42854 Based on observation, interview and record review, the facility failed to provide a minimum of 80 square feet (sq. ft. unit of measurement) per resident care area for eight (8) out of twenty-eight (28) resident rooms (Rooms 1, 2, 4, 5, 7, 8, 9, 33). The 8 resident rooms consisted of seven (7) - two (2) bed capacity rooms and one (1) four (4) bed capacity room. This deficient practice had the potential to impact the ability to provide safe nursing care and privacy to the residents. Findings: During an interview with the Administrator (ADM) on 3/14/2025 at 7 PM, the ADM stated the facility would like to request a room waiver for 8 resident rooms this year. The ADM stated nothing was changed and the number of bed occupancy in rooms 1,2,4,5,7,8,9, and 33 remained the same. A review of the facility ' s request for additional room waiver dated 3/15/2024 indicated the granting of the variance will not compromise the health, welfare, and safety of the residents. The request indicated the following resident bedrooms were: room [ROOM NUMBER] (2 beds) 1 resident 140 sq. ft. 70 sq. ft. room [ROOM NUMBER] (2 beds) 2 residents 140 sq. ft. 70 sq. ft. room [ROOM NUMBER] (2 beds) 1 resident 140 sq. ft. 70 sq. ft. room [ROOM NUMBER] (2 beds) 1 resident 144 sq. ft. 72 sq. ft. room [ROOM NUMBER] (2 beds) 1 resident 137 sq. ft. 68.5 sq. ft. room [ROOM NUMBER] (2 beds) 1 resident 140 sq. ft. 70 sq. ft. room [ROOM NUMBER] (2 beds) 2 residents 138 sq. ft. 69 sq. ft. room [ROOM NUMBER] (4 beds) 4 residents 277 sq. ft. 69.25 sq. ft. During a concurrent interview and record review of the facility ' s request for additional room waiver dated 3/14/2025 at 7:50 PM, the ADM stated there have been no complaints from residents, resident families, and staff about the room size. The ADM stated there was enough room to accommodate wheelchair and other medical equipment for adequate movement of ambulatory residents. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During the survey, from 3/14/2025 to 3/16/2025, there were no observed adverse effects as to the adequacy of space, nursing care, comfort, and privacy to the residents. The residents residing in the affected rooms (room [ROOM NUMBER], 2, 4, 5, 7, 8, 9, and 33) with an application for variance were observed to have enough space for the residents to move freely inside the rooms. Each resident inside the affected rooms had beds and bedside tables with drawers. There was an adequate room for the operation and use of the wheelchairs (a chair fitted with wheels for use as a means of transport by a person who is unable to walk as a result of illness, injury, or disability), walkers (is a device that gives additional support to maintain balance or stability while walking,), or canes. The room variance did not affect the care and services provided to the residents when nursing staff were observed providing care to the residents.