

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Temple Park Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 2411 W. Temple Street Los Angeles, CA 90026	

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 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524</p> <p>Based on interview and record review, the facility failed to sufficiently prepare one of three sampled resident (Resident 1) for a safe and orderly discharge from the facility to the resident ' s home, by failing to include the resident ' s significant other who was the primary care giver in the discharge process and by failing to ensure all necessary medical equipment and supplies were ordered.</p> <p>This failure resulted in resident 1 not having the appropriate Durable Medical Equipment (DME - any medical equipment used in the home to aid in a better quality of living) necessary for safe ambulation and transfer, and with no support/relief for the caregiver (CG). Placing Resident 1 at risk for accidents, injuries, and/ death.</p> <p>Findings:</p> <p>A review of Resident 1 ' s admission record indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including functional quadriplegia (complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the spinal cord. Patients with functional quadriplegia typically require total care, and high utilization of nursing resources), neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), and essential hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition).</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS- a standardized assessment and care screening tool), dated 3/7/2024, indicated Resident 1 was cognitively intact (mental ability to make decisions of daily living) and required one-person physical assist with bed mobility, dressing, toileting, and personal hygiene. The MDS indicated Resident 1 was independent for Activities of Daily Living (ADLs) such as eating, oral hygiene, toileting hygiene, personal hygiene. The MDS indicated, Resident 1 required to use a motorized wheelchair for movement.</p> <p>A review of Resident 1 ' s care plan initiated 9/7/2023, indicated Resident 1 had a potential/risk for fall/injury related to the diagnosis of functional quadriplegia. Interventions included to keep pathways clear and clear from clutter.</p> <p>(continued on next page)</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
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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1 ' s care plan initiated 3/18/2024, indicated Resident 1 was at risk for ADL decline related to the aging process and generalized weakness. Interventions included: to assist with daily personal hygiene in brushing teeth and combing hair and to check every two hours for soiling/wetness and thoroughly cleanse after each episode of incontinence (lack of voluntary control over urination or defecation).</p> <p>A review of Resident 1 ' s care plan initiated 3/18/24 indicated, Resident 1 had Peripheral Vascular Disease (PVD- a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel) with interventions which included educate resident to use caution with heating pads, hot water bottles. Educate the resident on the importance of proper foot care. Encourage good nutrition and hydration. Encourage resident to change positions frequently, not sit in one position for a long time. Monitor the extremities (limb of the body, such as the arm or leg) for signs and symptoms of injury, infection, or ulcers.</p> <p>During a concurrent interview and record review of Resident 1 ' s Social Services notes with the Social Worker (SW) on 5/21/24 at 11:26 pm, the SW stated that Resident 1 was initially going to be discharged to an assisted living facility and then decided to go home with family member 1 (FM 1). The SW confirmed by stating she (SW) did not meet with FM 1 to discuss and provide education as required by the facility policy for a safe and smooth discharge. The social services notes indicated; Resident 1 was discharged to the residence of FM 1. The notes indicated, FM 1 would be helping Resident 1 with all needs and appointments. The SW confirmed she had never spoken with FM 1 and stated the potential effect of not involving FM 1 could be that FM1 would not be aware of the specific instructions to follow.</p> <p>During an interview with FM 1 on 5/22/24 at 8:26 am, FM 1 stated she (FM 1) was feeling stressed and somewhat burnt out because FM 1 was made to believe that Resident 1 was going to be discharged to an assisted living facility but was surprised when Resident 1 suddenly told FM 1 that he was going to be discharged to FM 1 ' s house. FM 1 quickly arranged for a ramp to be placed at her apartment which was very costly for her. FM 1 resided in an apartment and stated it was impossible to navigate parts of the apartment such as the bathroom, which was not only tight, but the toilet was too low for resident 1 to get up safely. FM 1 stated the facility declined to have Resident 1 go to an assisted living facility and told the resident to go home instead and the facility would arrange caregiving services, and a hospital bed which would make it easier for Resident 1 to transfer in an out of bed. FM 1 stated none of those services had been provided. FM 1 stated that the bed was too low which had made it extremely difficult to transfer Resident 1 in and out of bed. FM 1 stated that she would have liked to be part of the discharge process to receive training, education, as well as resources as FM 1 was feeling unprepared, fatigued, and scrambling to find where to receive any type of assistance. FM 1 had to give up full time employment to be a full-time caregiver for Resident 1.</p> <p>A review of a facility policy and procedures (P&P) titled Transfer or Discharge of the Resident dated 4/21/2023, indicated The facility will provide discharge planning to ensure continuity of care for anticipated discharges.</p> <p>A review of an undated P&P titled Social Services, indicated the social services department was responsible for Participating in the planning of the resident's admission, return to home and community, or transfer to another facility by assessing the impact of these changes and making arrangements for social and emotional support.</p>		