STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555019	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple Park Convalescent Hospital	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 45524 Based on observation, interview, and record review, the facility failed to ensure one of nine sampled residents (Resident 1), who was identified with wandering episodes, was provided supervision, and maintained a safe and hazard free environment as indicated in Resident1 ' s care plan dated 2/21/2024. The facility failed to ensure a full bottle of hand sanitizer was not within Resident 1 ' s access or reach. As a result, Resident 1 ingested (drank) a toxic substance (hand sanitizer, a liquid or gel, typically one containing alcohol, that is used to clean the hands and kill bacteria, viruses, and other disease-causing agents on the skin) requiring admission to the General Acute Care Hospital (GACH) and was diagnosed with toxic encephalopathy (a neurologic disorder [nervous system problems] caused by consumption or exposure of harmful chemicals/toxins, that cause lead to altered mental status, memory loss, and visual problems). On 7/24/2024 at 3:58 pm., an Immediate Jeopardy (IJ - a situation in which the provider's non-compliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident) was identified and the facility was notified of the IJ in the presence of the Assistant Administrator (AADM) and the Director of Nursing (DON), regarding the facility's failure to provide supervision and an environment free from accident hazards to prevent Resident 1 from ingesting (drinking) a toxic substance (hand sanitizer). The facility was aware Resident 1 had wandering behavior and would pick up items and place the items in her mouth. 1. On 7/7/24, Resident 1 was left unsupervised at the nurses' station and ingested approximately 160 cubic centimeters (cc- unit of measurement) of hand sanitizer. As a result, Resident 1 was admitted to the GACH and diagnosed with toxic encephalopathy and dehydration. 2. On 7/23/2024 at 1:22 pm, the facility's reception area was observed with no staff present and with a half full bottle of hand sanitizer on top of the reception desk. 3. On 7/23/2024 at 4:22 pm, during an observation of the facility's dining room Resident 1 was observed unsupervised with the door closed sitting next to a desk and one opened bottle (approximately 1 liter) of sanitizing wipes within reach of Resident 1. A sanitizing wipe was observed hanging out of the top of the container. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. On 7/23/24 at 4:44 pm, during an observation of the facility's Maintenance Room, where cleaning solutions/chemicals were stored, the closet door was observed unlocked. There were no staff observed near the Maintenance Room to monitor and ensure no residents were not going inside the closet. Inside the Maintenance Room there was a door to a wired cage where cleaning solutions/chemicals were stored. There were observed stored several cleaning supplies and chemicals such as bleach and aerosols. The wired cage door was observed wide open, making cleaning supply available to residents. 5. On 7/23/24 at 5:57 pm, the facility's maintenance room door was observed opened with no staff present. On 7/26/2024 at 3:35 pm, the IJ was removed in the presence of the AADM, DON, Director of Staff Development (DSD), and Assistant Director of Nursing (ADON) after the onsite verification of the implementation of the IJ removal plan through observation, interview, and record review. The acceptable IJ removal plan included the following: 1. Resident 1 is being monitored by Licensed Vocational Nurse (LVN) for behavior manifested by an episode of ingesting fluids/liquid not suitable for human consumption. On 7/7/2024, Resident 1 was sent to acute hospital as ordered by the Attending Physician for further evaluation and is currently back in the facility with no sign or symptoms of intoxication. On 7/25/2024, IDT met to discuss resident current behavior and IDT recommended for facility to provide 1:1 supervision while awake. 2. On 7/25/2024 at 7:55am, Medical Director (MD), who is also Resident ' s primary physician, was contacted by the AADM and made aware of the facility's current IJ status. 3. On 7/23/2024, the Receptionist and DON removed the bottle of hand sanitizer on top of Facility's reception area. 4. On 7/23/2024, the Assistant Activity Director (AAD) and the DON removed the sanitizing wipes hanging on the top of the container inside of the facility's dining room. 5. On 7/23/2024, the Maintenance Director (MTD) locked the Maintenance Room and the wired cage. On 7/24/2024, MTD replaced the doorknob on the self-closing door located in the maintenance room, the door now self-locks. The MTD and/or Social Services Designee (MOD to check on weekend), will check the maintenance room around 10am, Minimum Data Set Nurse (MDSN) and/or Infection Preventionist (IP), (manager of the day (MOD) to check on weekend) will check around 3 pm and Desk Nurse and/or CART 2 Licensed Vocational Nurse (LVN) will check around 7 pm utilizing the Maintenance Room to ensure door was locked when room was unattended, noncompliance will be reported immediately to Administrator and/or DON. On 7/25/2024, the Registered Nurse (RN) Consultant reeducated the MTD the importance of locking the door where the facility keeps cleaning supply/chemicals to prevent visitors and residents' access. 6. On 7/23/2024 and 7/24/2024, The department heads consisting of the Business office manager, admissions coordinator, MDS Coordinator, Social Services Director (SSD), MTD, DSD, ADON, Dietary Supervisor, Discharge Planner, DON, immediately checked all the facility's common areas and removed all loose bottles of Alcohol-based hand rub (ABHR- is the preferred method for standard hand hygiene, kills the majority of viruses [an infectious agent that can only replicate within a living thing] from hands) to prevent any resident from accidentally ingesting toxic substances. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. The IP, Activity Director (AD) would conduct daily room rounds before stand-up meeting at 9:30 a.m., utilizing a log Loose bottles hand sanitizer check to ensure that there are no loose bottles, noncompliance will be reported immediately to Administrator (ADM) and/or DON. of hand sanitizer available inside the facility for one month and weekly thereafter. Loose bottles of ABHR were disposed. Beginning 7/24/2024, Central Supply Staff will no longer order loose bottle hand sanitizer and removed current loose bottle hand sanitizer from the facility and disposed accordingly. 8. On 7/24/2024, the seven residents identified by the facility to be at risk of wandering were being observed by the licensed nurses when approaching ABHR dispensers to ensure residents will not accidentally or intentionally ingest ABHR. The monitoring will be documented on the electronic health record (EHR). Licensed Nurses to report immediately if resident safety is compromised to the ADM and/or DON and in the absence of ADM or DON, the incident would be reported to ADON or designee. Licensed Nurses to inform Certified Nursing Assistants by providing a list of residents identified to be at risk of wandering that are being observed by licensed nurses for when approaching ABHR dispensers to ensure residents will not accidentally or intentionally ingest ABHR. List of residents will be updated by Licensed Nurses when there is resident identified during admission to be high risk, when resident is being transferred or discharged or with change of condition. 9. On 7/25/2024, RN Nurse Consultant educated facility department heads which included (DON, ADM, AADM, DSD, IP, MD, AD, Social Services Designee, Dietary supervisor (DS), Business Office Manager (BOM), ADON, Admission Coordinator) regarding the importance Identifying environmental hazards/risks (such as housekeeping chemicals or ABHR and implementing interventions to prevent accidents. The Department Heads that were not able to attend the in-service will be reeducated by DON before they return to work regarding the importance of Identifying environmental hazards/risks. Beginning 7/25/24 and ongoing the DON and ADON provided reeducation to all staff regarding the importance of maintaining toxic substances such as hand sanitizers out of reach of residents and importance of locking the door where facility keeps cleaning supply/chemicals to prevent visitors and residents' access. As of today, the facility has 121 total staff of which 17 are on vacation or out sick. There are 77 staff who completed the in-service, remaining 44 (including the 17 staff) Staff that were not able to attend the in-service will not be allowed to work until in service is completed. The DON and/or ADON and in the absence of both, the DSD and/or Infection Preventionist will review the checklist of facilities who were not in-serviced to ensure staff will be in-serviced before coming back to work. 10. On 7/25/24, the facility begun a Performance Improvement Plan (PIP) titled Toxic substances storage and supervision of residents with following goals and interventions: i. The resident environment remains as free of accident hazards as possible. ii. Each resident receives adequate supervision and assistance devices to prevent accidents by ensuring the MTD, the maintenance department staff and (4) housekeeping/laundry staff understood the importance of locking the door where the facility keeps cleaning supplies/ chemicals to prevent visitors and residents' access. Newly hired Maintenance staff and housekeeping staff will be in-serviced by MTD regarding the importance of locking the door where facility keeps cleaning supply/chemicals to prevent visitors and residents' access before 1st day of work. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	iii. The Interdisciplinary Team consisting of the BOM, Admissions Coordinator, MDS Coordinator, Social Services Director (SSD), MTD, DSD, ADON, DS, Discharge Planner, IP, AD, would conduct daily room rounds before stand-up meeting at 9:30 a.m., utilizing a log Loose bottles hand sanitizer check to ensure that there are no loose bottles, noncompliance will be reported immediately to ADM and/or DON. iv. Licensed Nurses to inform Certified Nursing Assistants (CNAs) by providing a list of residents identified to be at risk of wandering that are being observed by licensed nurses for when approaching ABHR dispensers to ensure residents will not accidentally or intentionally ingest ABHR. List of residents will be updated by Licensed Nurses when there is resident identified during admission to be high risk, when resident is being transferred or discharged or with change of condition. D v. Department Heads that were not able to attend the in-service will be reeducated by DON before they return to work regarding the importance of Identifying environmental hazards/risks. Department heads which did not attend the training, will not be allowed to work until in service is completed. (such as housekeeping chemicals or ABHR {Alcohol based hand rub) and implement interventions to prevent accidents. vi. The DON and/or ADON and in the absence of both, the DSD and/or Infection Preventionist would review the checklist of facility who were not in-serviced to ensure staff will be in-serviced before coming back to work. The PIP target end date is 8/30/24, the facility would evaluate its effectiveness weekly or as necessary to ensure its approaches/interventions are effective. If approaches are deemed ineffective the team will discuss new approaches/interventions. IF PIP is found ineffective QAPI committee which includes the ADM, the MD, the DON, ADON, MDS Coordinator, Medical Records Director, SSD, MTD, DSD, DS, Discharge Planner, IP, would update or revise interventions. Findings: During a review of Resident 1 ' s admission record, the record indicated the facility initially admitted Resident 1 on 2/17/2024 and was readmitted on ,d+[DATE]//2024 with diagnoses that included toxic encephalopathy, dementia (loss of cognitive functioning-thinking, remembering, and reasoning), chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe), and aphasia (loss of ability to understand or express speech, caused by brain damage). During a review of Resident 1 ' s care plan (CP) titled, Resident with wandering episode secondary to: Dementia initiated 2/21/2024, the CP indicated for interventions: Constant monitoring of whereabouts and maintain safe and hazard free environment. During a review of Resident 1 ' s Minimum Data Set (MDS- standardized data collection tool used to assess cognitive and functional status, and care needs) dated 6/23/2024, indicated Resident 1 had severe cognitive impairments (when social and occupational functions are limited where an individual may not be able to recognize people, use language, or execute purposeful movements). The MDS indicated Resident 1 required between partial/moderate to substantial/maximal assistance for Activities of Daily Living (ADLs - eating, oral hygiene, toileting, showers/bathing, dressing, personal hygiene, and toilet transfer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1 ' s History and Physical (H & P) dated 6/8/2024, the H & P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1 ' s nurse progress notes dated 7/7/2024 at 4:30 pm indicated Resident 1 had ingested 165 cc of hand sanitizer, called Medical Doctor (MD) with new orders to transfer out to hospital to monitor for symptoms of intoxication (is the condition of having physical or mental control markedly diminished by the effects of alcohol or drugs). During a review of Resident 1 ' s nurse progress notes dated 7/7/2024 at 6 pm indicated Resident 1 was picked up by two Emergency Medical Technicians (EMTs- a person who is trained to give emergency medical care at the scene of an accident or in an ambulance) in an ambulance going to GACH for further evaluation for ingestion of alcohol hand sanitizer. During a review of Resident 1 ' s physician ' s order dated 7/7/2024 at 4:30 pm, indicated transfer resident to hospital for further evaluation of ingestion of hand sanitizer. During a review of Resident 1 ' s CP initiated on 7/7/2024 for behavioral problems, the care plan indicated, resident ingested almost 165cc of hand sanitizer, resident is more confused. Wandering. During a review of Resident 1 ' s GACH History and Physical (H&P) records dated 7/12/24 under assessment and plan indicated the following: Toxic encephalopathy due to ingestion of hand sanitizer, cognitive impairment (Problems with a person's ability to think, learn, remember, use judgement, and make decisions) and altered mental status upon admission, consistent with toxic encephalopathy. The same H&P indicated, monitor neurological status (consists of a physical examination to identify signs of disorders affecting your brain, spinal cord, and nerves) and mental alertness every 2 hours. Administer intravenous (a way of giving a drug or other substance through a needle or tube inserted into a vein) fluids and electrolytes (minerals in your blood and other body fluids that carry an electric charge) to manage dehydration (a condition that occurs when the body loses too much water and other fluids that it needs to work normally) due to ingestion. Provide activated charcoal (a fine, odorless, black powder often used in emergency room s to treat overdoses) if within ingestion window to reduce systemic absorption (the movement of drug from the site of drug administration to the systemic circulation). Consult Poison Control Center for further management and antidote (a remedy to cancel the effects of poison) recommendations PRN (as needed) for complex cases. During an interview with LVN 3 on 7/23/2024 at 12:21 pm, stated that on 7/7/2024 at 4:30 pm while he (LVN 3) was sitting on the inside of the nurses ' station, LVN 3 observed Resident 1 who was sitting on a wheelchair grab a bottle of hand sanitizer which was full (221 cc) opened it, and started drinking it. LVN 3 stated that Resident 1 drank 165 cc of the hand sanitizer. LVN 3 admitted that Resident 1 was known (no time stated) to place items in her mouth that she could get her hands on, but that the behavior was not care planned. During a concurrent observation of the reception desk and interview with the DSD on 7/23/24 at 1:22 pm, the DSD confirmed and stated that there was no staff present at the reception desk. The DSD stated the sanitizer should be at the receptionist desk but was unable to state how the facility would prevent a confused resident with easy access from consuming the hand sanitizer. The DON stated the hand sanitizer could be toxic if consumed especially that residents are taking medications. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent observation of a desk in the admission ' s office and interview with the DON 7/23/24 1:27 pm, a loose bottle of hand sanitizer was observed within easy access for residents. The DON admitted the residents had access to the office and that the residents who are confused might consume the easily accessible hand sanitizer. The DON stated the potential effect if consuming hand sanitizer may be toxic and require medical attention. The affected resident may result in resident getting drunk. During a concurrent observation of Resident 1, interview, and record review with the ADON on 7/23/24 at 4:22 pm, Resident 1 ' s admission records dated 7/12/24 was reviewed. Resident 1 was readmitted to the facility on [DATE]. Resident 1 was observed sitting on a chair against the wall in the dining room unsupervised with the door closed. Right behind Resident 1 within easy access was a wall mount containing two boxes of gloves and another one next to the gloves containing about one liter of sanitizing wipes with one wipe hanging over the container. The ADON as well as the activities staff (AS) confirmed the observation. The ADON admitted that Resident 1 had easy access to the sanitizing wipes and could ingest them with her history of ingesting nonedible substances. During a concurrent observation and interview of the maintenance room (just across the hallway from the dining room approximately 30 feet from the dining room where Resident 1 was sitting) on 7/23/24 at 4:48 pm with the DON, the door was tied open using a string connected to the doorknob and a wire behind the door. There were no staff observed near the Maintenance Room to monitor and ensure no residents were not going inside the room. Inside the Maintenance Room there was a door to a wired cage where cleaning solutions/chemicals were stored. There were observed stored several cleaning supplies and chemicals such as bleach and aerosols. The wired cage door was observed wide open, making cleaning supply available to residents. The DON confirmed the observation and admitted that the room was easily accessible to residents. During a concurrent observation and interview with the DON of the Maintenance Room on 7/23/24 at 5:57 pm, The Maintenance Room was unattended, and the doors were open, and the caged door (containing cleaning supplies) was open. The DON confirmed and stated that residents had easy access and may consume the chemicals stored in the room. During an interview with Resident 1 ' s Primary Medical Doctor/Medical Director (PMD/MD) on 7/24/24 at 10 am, PMD/MD stated that Resident 1 required a 1:1 sitter after the incident on 7/7/24 for safety to prevent her from consuming toxic substances. The potential effects of consuming these toxic substances may result in metabolic acidosis (too much acid in the blood and can be life-threatening if not treated appropriately), esophageal strictures (narrowing of your esophagus (swallowing tube), cell injury, and death. During a review of the facility ' s policy and procedures (P&P) title Dementia-Clinical Protocol. Resident Behavior , release date 8/1/2023, the P & P indicated, The physician will order appropriate interventions to address significant behavioral and psychiatric symptoms, based on pertinent clinical guidelines and consistent with regulatory requirements. During a review of the facility ' s P & P titled Alcohol-Based Hand Rub Dispensers, Installation and Use, release date 1/2024, the P & P indicated, Alcohol-based hand rub dispensers shall be installed in areas that facilitate access by healthcare personnel and maintain a safe environment for the residents and staff. The same P&P indicated processes which included: Residents with cognitive or behavioral challenges and will be observed when they are near Alcohol Based Hand Rub (ABHR) dispensers.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on observation, interview and record review, the facility failed to maintain medical records for one of nine sampled residents (Resident 1) in accordance with accepted professional standards and practices by ensuring accurate documentation. This deficient practice had the potential to result in confusion in the care and services rendered to Resident 1 as evident by the inaccurate information entered into Resident 1's clinical record. Findings: During a review of Resident 1 ' s admission record indicated the facility initially admitted the on 2/17/2024 and readmitted on ,d+[DATE]//2024 with diagnoses that included toxic encephalopathy, dementia (loss of cognitive functioning-thinking, remembering, and reasoning), chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe), and aphasia (loss of ability to understand or express speech, caused by brain damage). During a review of Resident 1 ' s Minimum Data Set (MDS- standardized data collection tool used to assess cognitive and functional status, and care needs) dated 6/23/2024, indicated Resident 1 had severe cognitive impairments (when social and occupational functions are limited where an individual may not be able to recognize people, use language, or execute purposeful movements). The MDS indicated Resident 1 required between partial/moderate to substantial/maximal assistance for Activities of Daily Living (ADLs - eating, oral hygiene, toileting, showers/bathing, dressing, personal hygiene, and toilet transfer. During a review of Resident 1 ' s document titled ADMISSION NURSING RISKS EVALUATION/ASSESSMENTS, dated 7/12/2024 at 7:36 pm, indicated, admitted a [AGE] year-old male from General Acute Care Hospital (GACH) with diagnoses which included, right leg swelling with scab (a dry, rough protective crust that forms over a cut or wound during healing). The treatment included cleanse with normal saline (NS- an aqueous solution of electrolytes and other hydrophilic molecules) pat dry. Paint with betadine (topical aqueous solution of 10% povidone-iodine), cover with dry dressing. Documented indicated, give clindamycin (an antibiotic that fights bacteria in the body) 300mg 1 tablet orally daily for 10 days. During an interview with the Director of Nursing (DON), on 8/7/24 at 11:46 am, the DON confirmed and stated the facility had failed to identify the wrong information. DON stated that the potential effect could result in a compromised care for Resident 1. During a review of the facility's policy and procedures (P&P) titled CHARTING AND DOCUMENTATION, reviewed 6/18/2024 indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The same P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.