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	08/09/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on interviews, and record reviews the facility failed to implement abuse policy and procedure when the facility failed to report to the State Agency: 1. The alleged abuse between two residents (Residents 3 and 4). 2. The injury of unknown origin for Resident 5. This deficient practice resulted in Resident 3 and Resident 4 exposed to continuous verbal and mental abuse and for Resident 5 with a potential for contiuned physical abuse. Cross Reference: F726. Findings: 1. During a review of Resident 3's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included hepatic encephalopathy (a serious and potentially reversible condition that can affect individuals with advanced liver dysfunction), alcoholic cirrhosis of the liver (a condition that occurs when the liver is permanently damaged by alcohol, causing scar tissue to replace healthy tissue), and insomnia (a common sleep disorder that makes it difficult to fall asleep, stay asleep, or get quality sleep). During a review of Resident 3's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 6/24/2024 indicated Resident 3 was cognitively (the mental ability to understand and make decisions of daily living) intact. The MDS indicated Resident 3 required between partial moderate assistance to setup or clean up assistance for Activities of Daily Living (ADL-eating, oral hygiene, toilet hygiene, shower/bathe, upper/lower body dressing, and personal hygiene). During a review of Resident 3's history and physical (H&P) dated 6/26/2024 indicated Resident 3 had the capacity to consent. (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

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	08/09/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of a Situation, Background, Assessment, and Recommendation (a communication tool used in nursing to help healthcare teams explain a patient's condition to each other) dated 8/4/2024 at 10:59 pm, indicated, Resident stated that he was hit with a stick by his roommate (Resident 4) and sustained right arm skin tear and discoloration, able to move right arm with no difficulty. Per resident (Resident 3) roommate (Resident 4) accused him of stealing his money on the atm card (Automated Teller Machine card, is a PIN-based card issued by a bank that allows account holders to access their funds at ATMs). 911 was called. During a review of Resident 3 ' s document titled Alert Charting dated 8/5/2024 at 11:52 am indicated, Resident 3 sustained a skin tear from an incident last night. Resident denies pain or discomfort related to the skin tear. During a review of Resident 4 ' s Admission Record FS indicated Resident 4 admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting left non-dominant side, depression (a mood disorder that causes persistent feeling of sadness and loss of interest), and dysphagia (difficulty swallowing food or liquid). During a review of Resident 5 ' s MDS dated [DATE], indicated the Resident 4 was cognitively intact. The MDS indicated Resident 4 required between partial moderate assistance to substantial/maximal assistance for all his ADLs. During a review of Resident 4 ' s H&P dated 6/19/2024 indicated, Resident 5 had the capacity to consent. During a review of a SBAR dated 8/6/2024 at 9:59 pm, indicated, resident (Resident 4) was physically aggressive with another resident (Resident 3). During a review of the interdisciplinary Team meeting (IDT- a group of dedicated healthcare professionals who work to bring knowledge together to help residents receive the care they need) notes dated 8/5/2024 at 9:37 am indicated, 8/5/2024 @2pm - The resident (Resident 4) stated that last night he and his roommate (Resident 3) ordered food together, roommate (Resident 3) took pictures of his debit card including the security code on the back. The roommate (Resident 3) also asked for the address associated with the card. The resident (Resident 4) suspected his roommate (Resident 3) was using his card when he overheard him talking to someone in the restroom. The resident (Resident 4) checked his debit card balance, which had decreased from $814 to $600. When he (Resident 4) confronted his roommate (Resident 3) about taking his money, the roommate (Resident 3) became upset used racial slurs and threw ice from the cup at him (Resident 4). In response the resident (Resident 4) hit the roommate (Resident 3) on the arm with a wooden stick. The resident (Resident 4) expressed that while he doesn't care about the money he is upset by the racial slurs. 2. During a review of Resident 5 ' s Admission Record FS indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including metabolic encephalopathy (a neurological disorder that causes brain dysfunction due to a chemical imbalance in the blood), dementia (a syndrome that causes a decline in cognitive abilities, such as memory, thinking, and problem-solving, that can interfere with daily activities), and dysphagia. (continued on next page)

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	08/09/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 5 ' s H&P dated 4/9/2023 indicated, Resident 5 did not have the capacity to consent. During a review of Resident 5 ' s MDS dated [DATE], indicated the resident had severe cognitive (the mental ability to make decisions of daily living) impairments. The MDS indicated Resident 5 was dependent on staff for all his ADLs. During a review of a Situation, Background, Assessment, and Recommendation (a communication tool used in nursing to help healthcare teams explain a patient's condition to each other) dated 8/6/2024 at 11:50 pm, indicated, While making a round, noted resident has skin discoloration of L lower eye and L ear. Resident unable to recall what happened due to pt confused and demented. During an observation of Resident 5 on 8/12/2024 at 11:13 pm, Resident 5 was observed to be asleep and did not respond to a soft call of his name or light touch. was observed to have a bruise under his left eye from the outer eye to the inner eye, measuring approximately 3.8 centimeters (cm) by 2.5 cm. the center of the bruise which measure about half a cm was raised and dark purple in color. The rest of the bruise was reddish yellowing in color with a purple line under the bruise from the inner eye to mid under eye. During an interview with the Assistant DON (ADON) on 8/12/24 at 12:36 pm, the ADON stated that Resident 5 may have scratched himself or hit his head against the siderail but that no one had witnessed the events that lead up to the bruising. The ADON did admit that the bruise was not consistent with a scratch. ADON confirmed that there was no investigation completed neither was the event reported to outside agencies such as the police, Department of Public Health (DPH), and the Ombudsman (an official appointed to investigate individuals' complaints against maladministration, especially that of public authorities). During a concurrent interview and record review of (Residents 3 and 4) physical abuse packet with the Social Worker Assistant (SWA) on 8/12/24 at 2:07 pm, there was no documented evidence that physical abuse was reported to the Ombudsman (an official appointed to investigate individuals' complaints against maladministration, especially that of public authorities) nor to the Department of Public Health (DPH). There was no documented evidence that the 72-hour monitoring (when SW visits the suspected abuse residents to ensure their emotional and mental well-being). She stated that the importance of reporting to the DPH was to ensure that facility had done what they needed to do and for the safety of the patient. During an interview with the Assistant Administrator (AADM) on 8/12/24 at 3:19 pm, the AADM admitted that Resident 5 ' s bruise would be considered an injury of unknown origin because Resident 5 was confused and unable to verbalize what had happened and no one witnessed what lead up to the injury. AADM admitted that an injury of unknown must be investigated to prevent further injury to the resident and reported to the Ombudsman, police, and DPH. The AADM confirmed that a 72-hour monitoring should have been done every day for 3 days. During a review of a the facility's policy and procedure (P&P) titled Unusual Occurrence Reporting, revised 9/2023 indicated, As required by federal or state regulations, our facility repo1ts unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors. The same P&P indicated under policy interpretation that the facility would report events which included: (continued on next page)

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	08/09/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Allegations of abuse, neglect and misappropriation of resident property. During a review of the facility's P&P titled Abuse prevention program- Resident Behavior, revised 6/18/2024, indicated under policy interpretation that as part of the facility ' s abuse prevention, the administration would implement actions which included: i. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. ii. Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. iii. Identify and assess all possible incidents of abuse. iv. Investigate and report any allegations of abuse within timeframes as required by federal requirements.

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	08/09/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on interviews, and record reviews the facility failed to implement abuse policy and procedure when the facility failed to report to the State Agency: the injury of unknown for 0ne of the three sampled residents (Resident 5). This deficient practice had the potential exposed to continuous verbal and mental abuse from Resident 3 causing mental anguish and emotional distress. Findings: During a review of Resident 5 ' s Admission Record FS indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including metabolic encephalopathy (a neurological disorder that causes brain dysfunction due to a chemical imbalance in the blood), dementia (a syndrome that causes a decline in cognitive abilities, such as memory, thinking, and problem-solving, that can interfere with daily activities), and dysphagia (difficulty swallowing). During a review of Resident 5 ' s H&P dated 4/9/2023 indicated, Resident 5 did not have the capacity to consent. During a review of Resident 5 ' s MDS dated [DATE], indicated the resident had severe cognitive (the mental ability to make decisions of daily living) impairments. The MDS indicated Resident 5 was dependent on staff for all his ADLs. During a review of a Situation, Background, Assessment, and Recommendation (a communication tool used in nursing to help healthcare teams explain a patient's condition to each other) dated 8/6/2024 at 11:50 pm, indicated, While making a round, noted resident has skin discoloration of L lower eye and L ear. Resident unable to recall what happened due to pt confused and demented. During an observation of Resident 5 on 8/12/2024 at 11:13 pm, Resident 5 was observed to be asleep and did not respond to a soft call of his name or light touch. was observed to have a bruise under his left eye from the outer eye to the inner eye, measuring approximately 3.8 centimeters (cm) by 2.5 cm. the center of the bruise which measure about half a cm was raised and dark purple in color. The rest of the bruise was reddish yellowing in color with a purple line under the bruise from the inner eye to mid under eye. During an interview with the Assistant DON (ADON), on 8/12/24 at 12:36 pm, the ADON stated that Resident 5 may have scratched himself or hit his head against the siderail but that no one had witnessed the events that lead up to the bruising. The ADON did admit that the bruise was not consistent with a scratch. ADON confirmed that there was no investigation completed neither was the event reported to outside agencies such as the police, Department of Public Health (DPH), and the Ombudsman (an official appointed to investigate individuals' complaints against maladministration, especially that of public authorities). (continued on next page)

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	08/09/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Assistant Administrator (AADM), on 8/12/24 at 3:19 pm, the AADM admitted that Resident 5 ' s bruise would be considered an injury of unknown origin because Resident 5 was confused and unable to verbalize what had happened and no one witnessed what lead up to the injury. AADM admitted that an injury of unknown must be investigated to prevent further injury to the resident and reported to the Ombudsman, police, and DPH. The AADM confirmed that a 72-hour monitoring should have been done every day for 3 days. During a review of the facility's policy and procedure (P&P) titled Unusual Occurrence Reporting, revised 9/2023 indicated, As required by federal or state regulations, our facility repo1ts unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors. The same P&P indicated under policy interpretation that the facility would report events which included: - Allegations of abuse, neglect and misappropriation of resident property. During a review of the facility's P&P titled Abuse prevention program- Resident Behavior, revised 6/18/2024, indicated under policy interpretation that as part of the facility ' s abuse prevention, the administration would implement actions which included: i. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. ii. Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. iii. Identify and assess all possible incidents of abuse. iv. Investigate and report any allegations of abuse within timeframes as required by federal requirements. During a review of the facility's P&P titled ABUSE INVESTIGATION AND REPORTING, revised 3/2024 indicated, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to agencies as defined by current regulations and thoroughly investigated by facility management. The same P&P indicated under Policy interpretation and implementation the role of the administrator which included: - If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. The P&P indicated under reporting that all other instances of resident abuse, neglect, exploitation, misappropnat1on of resident property, mistreatment and/or injuries of unknown source (abuse) will be reported by the facility Administrator, or his/her designee, to the following agencies immediately or as soon as practicable, but not later than two hours after the incident occurred: a. The local/State Ombudsman. (continued on next page)

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	08/09/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Law enforcement officials. c. The State licensing/certification agency responsible for surveying/licensing the facility.

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	08/09/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on observation, interview, and record review, the facility failed to ensure 1. That licensed nurses had the specific competencies and skill sets necessary to adequately assess stage Pressure Ulcers (PU-injuries to skin and underlying tissue resulting from prolonged pressure on the skin. They most often develop on skin that covers bony areas of the body, such as the heels, ankles, hips, and tailbone. They range from stage 1 through stage 4: I-intact skin with redness, II-broken skin or intact blister involving top layer of the skin, III- broken skin extending to the fatty tissue, and IV- broken skin extending to the muscle or the bone) for one out of three sampled residents by failing to grade the stage 3 pressure ulcer. 2. To implement abuse policy and procedure when the facility did not Identify and assess all possible incidents of abuse (Resident 5). This failure had the potential to result in improperly treating the wound which may lead to the wound getting infected and also exposed Resident 5 to continuous physical abuse causing mental anguish, further injuries and emotional distress. Findings: 1. During a review of Resident 2 ' s Admission Record (FS) indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus 2 (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), dysphagia (swallowing difficulties where some people have problems swallowing certain foods or liquids, while others can't swallow at all), and dementia (a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities). 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 4/12/2024, indicated the resident had moderated cognitive (the mental ability to make decisions of daily living) impairments. The MDS indicated Resident 1 was dependent on staff for Activities of Daily Living (ADL-eating, oral hygiene, toilet hygiene, shower/bathe, upper/lower body dressing, and personal hygiene. During a review of the history and physical (a term used to describe a physician's examination of a patient in an H&P, the physician obtains a thorough medical history from the patient, performs a physical examination, and then documents their findings) dated 4/10/2024 indicated that Resident 1 did not have the capacity to consent. During a review of the admission nursing risks evaluation/assessment dated [DATE] indicated Resident 1 ' s was a high risk for skin breakdown. During an interview with the treatment nurse (TxN) on 8/9/24 at 1:51 pm, TxN stated he, along with the Director of Nursing (DON), Desk Nurse (DN), and Infection Preventionist Nurse/Quality Assurance Nurse (IPN/QAN) assessed Resident 1 on 4/10/24 and that her (Resident 1) skin was intact. (continued on next page)

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	08/09/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with DN on 8/9/2024 at 2:50 pm, DN stated that she (DN) had first assessed Resident 1 upon admission on 4/9/2024 and admitted that she was part of the team that had assessed Resident 1 on 4/10/2024. DN stated that Resident 1 ' s skin was intact upon both assessments. During an interview with the DON on 8/9/24 at 3:10 pm, the DON stated that Resident had a history of PUs to the coccyx (tailbone) area and had scarring due to the same. The DON admitted that the facility failed to appropriately assess and identify the PU. The DON stated that the potential effect of not appropriately assessing and identifying a PU may lead to resident not receiving the appropriate treatments. 2. During a review of Resident 5 ' s Admission Record FS indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including metabolic encephalopathy (a neurological disorder that causes brain dysfunction due to a chemical imbalance in the blood), dementia (a syndrome that causes a decline in cognitive abilities, such as memory, thinking, and problem-solving, that can interfere with daily activities), and dysphagia. During a review of Resident 5 ' s H&P dated 4/9/2023 indicated, Resident 5 did not have the capacity to consent. During a review of Resident 5 ' s MDS dated [DATE], indicated the resident had severe cognitive (the mental ability to make decisions of daily living) impairments. The MDS indicated Resident 5 was dependent on staff for all his ADLs. During a review of a Situation, Background, Assessment, and Recommendation (a communication tool used in nursing to help healthcare teams explain a patient's condition to each other) dated 8/6/2024 at 11:50 pm, indicated, While making a round, noted resident has skin discoloration of L lower eye and L ear. Resident unable to recall what happened due to pt confused and demented. During an observation of Resident 5 on 8/12/2024 at 11:13 pm, Resident 5 was observed to be asleep and did not respond to a soft call of his name or light touch. was observed to have a bruise under his left eye from the outer eye to the inner eye, measuring approximately 3.8 centimeters (cm) by 2.5 cm. the center of the bruise which measure about half a cm was raised and dark purple in color. The rest of the bruise was reddish yellowing in color with a purple line under the bruise from the inner eye to mid under eye. During an interview with the Assistant Director of Nursing (ADON), on 8/12/24 at 12:36 pm, the ADON stated that Resident 5 may have scratched himself or hit his head against the siderail but that no one had witnessed the events that lead up to the bruising. The ADON did admit that the bruise was not consistent with a scratch. ADON confirmed that there was no investigation completed neither was the event reported to outside agencies such as the police, Department of Public Health (DPH), and the Ombudsman (an official appointed to investigate individuals' complaints against maladministration, especially that of public authorities). During an interview with the Assistant Administrator (AADM) on 8/12/24 at 3:19 pm, the AADM admitted that Resident 5 ' s bruise would be considered an injury of unknown origin because Resident 5 was confused and unable to verbalize what had happened and no one witnessed what lead up to the injury. AADM admitted that an injury of unknown must be investigated to prevent further injury to the resident and reported to the Ombudsman, police, and DPH. (continued on next page)

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	08/09/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the DON job description indicated, the DON is responsible for provision of 24-hour nursing services to meet nursing needs of residents which includes the spiritual, emotional, cultural, social., and restorative needs and ensure resident care policies/procedures are designed and implemented to meet such needs. The DON ensures proper coordination of staffing, and scheduling of nursing personnel for assignment of duties that are consistent with their training and educational experience, based on type of resident acuity. The DON is totally responsible for staff development, maintenance of nursing service objectives, and standards of nursing practice and has twenty-four hour (24 hour) responsibility for resident care management and staff development to meet resident needs. During a review of the facility's policy and procedure (P&P) titled Pressure Ulcer/Skin Breakdown-Clinical protocol, reviewed 6/18/2024, indicated under assessment and recognition, 1. The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Assessment of pressure sore including location, stage, length, width, and depth. b. Pain assessment. c. Resident's mobility status. d. Current treatments, including support surfaces. e. Active diagnoses. 3. The staff will examine the skin of a new admission for ulcerations or alterations in skin. A review of the facility's P&P titled Unusual Occurrence Reporting, revised 9/2023 indicated, As required by federal or state regulations, our facility repo1ts unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors. The same P&P indicated under policy interpretation that the facility would report events which included: - Allegations of abuse, neglect and misappropriation of resident property. During a review of the facility's P&P titled Abuse prevention program- Resident Behavior, revised 6/18/2024, indicated under policy interpretation that as part of the facility ' s abuse prevention, the administration would implement actions which included: i. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. ii. Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. (continued on next page)

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	08/09/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	iii. Identify and assess all possible incidents of abuse. iv. Investigate and report any allegations of abuse within timeframes as required by federal requirements. During a review of a P&P titled Unusual Occurrence Reporting, revised 9/2023 indicated, Unusual occurrences shall be reported to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations. The same P&P indicated, A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) within forty-eight (48) hours of reporting the event or as required by federal and state regulations.

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	08/09/2024

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on interviews and record review the facility failed to have a full-time abuse coordinator (Administrator) in the facility. As a result, the incidents of abuse and neglect were not managed and addressed for three of three residents (Residents 3, 4, and 5). Cross Reference: F609 Findings: 1. During a review of Resident 3's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included hepatic encephalopathy (a serious and potentially reversible condition that can affect individuals with advanced liver dysfunction), alcoholic cirrhosis of the liver (a condition that occurs when the liver is permanently damaged by alcohol, causing scar tissue to replace healthy tissue), and insomnia (a common sleep disorder that makes it difficult to fall asleep, stay asleep, or get quality sleep). During a review of Resident 3's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 6/24/2024 indicated Resident 3 was cognitively (the mental ability to understand and make decisions of daily living) intact. The MDS indicated Resident 3 required between partial moderate assistance to setup or clean up assistance for Activities of Daily Living (ADL-eating, oral hygiene, toilet hygiene, shower/bathe, upper/lower body dressing, and personal hygiene). During a review of Resident 3's history and physical (H&P) dated 6/26/2024 indicated Resident 3 had the capacity to consent. During a review of a Situation, Background, Assessment, and Recommendation (a communication tool used in nursing to help healthcare teams explain a patient's condition to each other) dated 8/4/2024 at 10:59 pm, indicated, Resident stated that he was hit with a stick by his roommate (Resident 4) and sustained right arm skin tear and discoloration, able to move right arm with no difficulty. Per resident (Resident 3) roommate (Resident 4) accused him of stealing his money on the atm card (Automated Teller Machine card, is a PIN-based card issued by a bank that allows account holders to access their funds at ATMs). 911 was called. During a review of Resident 3 ' s document titled Alert Charting dated 8/5/2024 at 11:52 am indicated, Resident 3 sustained a skin tear from an incident last night. Resident denies pain or discomfort related to the skin tear. (continued on next page)

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	08/09/2024

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4 ' s Admission Record FS indicated Resident 4 admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting left non-dominant side, depression (a mood disorder that causes persistent feeling of sadness and loss of interest), and dysphagia (difficulty swallowing food or liquid). During a review of Resident 5 ' s MDS dated [DATE], indicated the Resident 4 was cognitively intact. The MDS indicated Resident 4 required between partial moderate assistance to substantial/maximal assistance for all his ADLs. During a review of Resident 4 ' s H&P dated 6/19/2024 indicated, Resident 5 had the capacity to consent. During a review of a SBAR dated 8/6/2024 at 9:59 pm, indicated, resident (Resident 4) was physically aggressive with another resident (Resident 3). During a review of the interdisciplinary Team meeting (IDT- a group of dedicated healthcare professionals who work to bring knowledge together to help residents receive the care they need) notes dated 8/5/2024 at 9:37 am indicated, 8/5/2024 @2pm - The resident (Resident 4) stated that last night he and his roommate (Resident 3) ordered food together, roommate (Resident 3) took pictures of his debit card including the security code on the back. The roommate (Resident 3) also asked for the address associated with the card. The resident (Resident 4) suspected his roommate (Resident 3) was using his card when he overheard him talking to someone in the restroom. The resident (Resident 4) checked his debit card balance, which had decreased from $814 to $600. When he (Resident 4) confronted his roommate (Resident 3) about taking his money, the roommate (Resident 3) became upset used racial slurs and threw ice from the cup at him (Resident 4). In response the resident (Resident 4) hit the roommate (Resident 3) on the arm with a wooden stick. The resident (Resident 4) expressed that while he doesn't care about the money he is upset by the racial slurs. 2. During a review of Resident 5 ' s Admission Record FS indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including metabolic encephalopathy (a neurological disorder that causes brain dysfunction due to a chemical imbalance in the blood), dementia (a syndrome that causes a decline in cognitive abilities, such as memory, thinking, and problem-solving, that can interfere with daily activities), and dysphagia. During a review of Resident 5 ' s H&P dated 4/9/2023 indicated, Resident 5 did not have the capacity to consent. During a review of Resident 5 ' s MDS dated [DATE], indicated the resident had severe cognitive (the mental ability to make decisions of daily living) impairments. The MDS indicated Resident 5 was dependent on staff for all his ADLs. During a review of a Situation, Background, Assessment, and Recommendation (a communication tool used in nursing to help healthcare teams explain a patient's condition to each other) dated 8/6/2024 at 11:50 pm, indicated, While making a round, noted resident has skin discoloration of L lower eye and L ear. Resident unable to recall what happened due to pt confused and demented. (continued on next page)

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	08/09/2024

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident 5 on 8/12/2024 at 11:13 pm, Resident 5 was observed to be asleep and did not respond to a soft call of his name or light touch. was observed to have a bruise under his left eye from the outer eye to the inner eye, measuring approximately 3.8 centimeters (cm) by 2.5 cm. the center of the bruise which measure about half a cm was raised and dark purple in color. The rest of the bruise was reddish yellowing in color with a purple line under the bruise from the inner eye to mid under eye. During an interview with the Assistant DON (ADON) on 8/12/24 at 12:36 pm, the ADON stated that Resident 5 may have scratched himself or hit his head against the siderail but that no one had witnessed the events that lead up to the bruising. The ADON did admit that the bruise was not consistent with a scratch. ADON confirmed that there was no investigation completed neither was the event reported to outside agencies such as the police, Department of Public Health (DPH), and the Ombudsman (an official appointed to investigate individuals' complaints against maladministration, especially that of public authorities). During a concurrent interview and record review of (Residents 3 and 4) physical abuse packet with the Social Worker Assistant (SWA) on 8/12/24 at 2:07 pm, there was no documented evidence that physical abuse was reported to the Ombudsman (an official appointed to investigate individuals' complaints against maladministration, especially that of public authorities) nor to the Department of Public Health (DPH). There was no documented evidence that the 72-hour monitoring (when SW visits the suspected abuse residents to ensure their emotional and mental well-being). She stated that the importance of reporting to the DPH was to ensure that facility had done what they needed to do and for the safety of the patient. During an interview with the Assistant Administrator (AADM) on 8/12/24 at 3:19 pm, the AADM admitted that Resident 5 ' s bruise would be considered an injury of unknown origin because Resident 5 was confused and unable to verbalize what had happened and no one witnessed what lead up to the injury. AADM admitted that an injury of unknown must be investigated to prevent further injury to the resident and reported to the Ombudsman, police, and DPH. The AADM confirmed that a 72-hour monitoring should have been done every day for 3 days. During a review of the facility's policy and procedure (P&P) titled Unusual Occurrence Reporting, revised 9/2023 indicated, As required by federal or state regulations, our facility repo1ts unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors. The same P&P indicated under policy interpretation that the facility would report events which included: - Allegations of abuse, neglect and misappropriation of resident property. During a review of a P&P titled Abuse prevention program- Resident Behavior, revised 6/18/2024, indicated under policy interpretation that as part of the facility ' s abuse prevention, the administration would implement actions which included: i. Protect our residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. (continued on next page)

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	08/09/2024

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ii. Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. iii. Identify and assess all possible incidents of abuse. iv. Investigate and report any allegations of abuse within timeframes as required by federal requirements. During a review of the administrator job description (JD) indicated the basic functions are The Administrator directs and coordinates all the activities of the facility to assure that the highest quality of care is provided to the medically fragile residents it serves. By supporting and interpreting the mission of Advanced Skilled Nursing incorporated (ASN). The Administrator is responsible for the integration of the Affiliate within the ASN. The JD indicated the position was a full time position with hours to be determined by programmatic needs.