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	12/31/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 36395 Based on observation, interview and record review, the facility failed to provide mouthcare regularly for one of three sampled residents (Resident 1). During observation on 12/30/24 at 10 a.m., Resident 1 was observed with creamy substance at the corner of the left mouth, tongue was coated with white crust and the lower lip was dry with crusts. This deficient practice had the potential for Resident 1 to suffer from pain and infection. Findings: During a review of the Admission Record indicated the facility admitted Resident 1 on 7/18/24 with diagnoses including dementia (progressive sate of decline in mental abilities), Alzheimer's disease (progressive decline in mental abilities) and need for assistance with personal care. During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 10/21/24 indicated Resident 1 had severe cognitive impairment. Resident 1 needed substantial assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, putting/taking off footwear, personal hygiene, and moderate assistance (helper does less than half the effort) with eating, oral hygiene, and upper body dressing. During a review of care plan initiated on 10/30/24 indicated Resident 1 had dental health problems, all teeth are missing. The care plan goal indicated Resident 1 will comply with mouth care at least daily through the review date. Nursing interventions included to provide mouth care as per activities of daily living personal hygiene. During a review of the care plan initiated on 11/17/24 indicated Resident 1 was at risk for oral pain, weight loss, infection related to inflamed gums, swollen or bleeding gums. The care plan goal indicated Resident 1 will have no dental infection for 90 days. Interventions included provide good oral hygiene every morning, after meals, before bedtime and as needed. During observation on 12/30/24 at 8:47 a.m., Resident 1 was observed with creamy substance at corner of the left mouth. During concurrent interview, certified nursing assistant (CNA 1) stated the creamy substance is the oatmeal from breakfast. Observed CNA 1 obtained a wet washcloth and proceeded to wipe off the creamy substance from Resident 1's mouth but failed to provide oral care. (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: 555019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER: Temple Park Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE: 2411 W. Temple Street Los Angeles, CA 90026	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 12/30/24 at 10:32 a.m., observed Resident 1's lower lips with crusts and Resident 1's tongue was coated with white film. During concurrent interview, CNA 2 stated Resident 1's mouth is not clean and resident needs mouthcare . CNA 2 stated oral care should be done regularly. During an interview on 12/30/24 at 10:47 a.m., the registered nurse supervisor (RNS 1) stated we make sure that we take good care of Resident 1. During a review of the facility Policy titled Activities of Daily Living (ADLs), Supporting reviewed on 6/18/24 indicated residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, and oral hygiene. The same Policy indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with consent of the resident and in accordance with the plan of care, including appropriate support and assistance that included hygiene (bathing, dressing, grooming and oral care).

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 12/31/2024
NAME OF PROVIDER OR SUPPLIER Temple Park Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 2411 W. Temple Street Los Angeles, CA 90026	

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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 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. 36395 Based on interview and record review the facility failed to ensure the records for residents were complete and accurate for one of three sampled residents (Resident 1). For Resident 1, the facility failed to ensure the fluid and oral intake were accurately documented on 12/15/24,12/16/24, 12/17/24 and 12/29/24. This deficient practice resulted in failing to determine the oral and fluid intake of Resident 1. Findings: During a review of the Admission Record indicated the facility admitted Resident 1 on 7/18/24 with diagnoses including dementia (progressive sate of decline in mental abilities), Alzheimer's disease (progressive decline in mental abilities) and need for assistance with personal care. During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 10/21/24 indicated Resident 1 had severe cognitive impairment. Resident 1 needed substantial assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, putting/taking off footwear, personal hygiene, and moderate assistance (helper does less than half the effort) with eating, oral hygiene, and upper body dressing. During a review of Resident 1's CNA daily Charting Form for 12/24 indicated, Resident 1's oral and fluid intake were not recorded during the afternoon shift on 12/15/24, 12/16/24, 12/17/24 and 12/29/24. During an interview on 12/30/24 at 11:27 a.m., the registered dietitian (RD) stated it is important to know the oral and fluid intake of Resident 1 to find out if there are any changes in Resident 1's oral intake. During a concurrent interview and record review on 12/30/24 at 12:29 p.m. Resident 1's CNA Daily Charting Form for 12/24 was reviewed with the director of nursing (DON). The DON agreed that the documentation for oral and fluid intakes for the afternoon shift on 12/15/24,12/16/24, 12/17/24 and 12/29/24 were blank. DON stated the Resident 1's oral intake should be monitored, and the nurse forgot to document. During a review of the facility Policy titled Charting and Documentation reviewed on 6/18/24 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 Policy indicated documentation in the medical record will be objective (not opinionated or speculative) complete and accurate.