

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 01/14/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252</p> <p>Based on interview and record review, the facility failed to develop and implement a care plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) for one of three residents (Resident 2's) right hand swelling noted on 1/5/25.</p> <p>This failure had the potential to negatively affect the delivery of care and services.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record dated 1/14/25, it was indicated that Resident 2 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), muscle weakness, hypertension (high blood pressure), dysphagia (difficulty swallowing), abnormal posture, and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).</p> <p>During a review of Resident 2's History and Physical (H&P), dated 7/19/24 indicated the patient did not have the capacity (ability) to consent, the reason being dementia.</p> <p>During a review of Resident 2's Minimum Data Set (MDS-an assessment tool) dated 10/21/24 indicated the resident had severely impaired cognition (mental action of understanding, reasoning, thinking, judgment, thought) and required partial/moderate assistance (helper does less than half the effort) for eating, oral hygiene, and upper body dressing and bed mobility and required substantial/maximal assistance (helper does more than half the effort) for bed mobility, toileting, bathing/showering, lower body dressing, personal hygiene, and sit to stand.</p> <p>During a review of Resident 2's SBAR (Situation Background Assessment Recommendation) Communication Form and progress note dated 1/5/25 indicated Resident 2 had a change in condition of right-hand edema (swelling).</p> <p>During a concurrent interview and record review on 1/14/15 at 4:45 pm with the Director of Nursing (DON), Resident 2's care plans were reviewed. DON verified there was no care plan for the problem of right-hand edema in the resident's record and stated every problem had to have a care plan.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility policy and procedures, Care Planning - Interdisciplinary Team reviewed 6/18/24, indicated the care plan is based on the resident's comprehensive assessment and is developed by a care planning/interdisciplinary team.</p> <p>Based on interview and record review, the facility failed to develop and implement a care plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) for one of three residents (Resident 2's) right hand swelling noted on 1/5/25.</p> <p>This failure had the potential to negatively affect the delivery of care and services.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record dated 1/14/25, it was indicated that Resident 2 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), muscle weakness, hypertension (high blood pressure), dysphagia (difficulty swallowing), abnormal posture, and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).</p> <p>During a review of Resident 2's History and Physical (H&P), dated 7/19/24 indicated the patient did not have the capacity (ability) to consent, the reason being dementia.</p> <p>During a review of Resident 2's Minimum Data Set (MDS-an assessment tool) dated 10/21/24 indicated the resident had severely impaired cognition (mental action of understanding, reasoning, thinking, judgment, thought) and required partial/moderate assistance (helper does less than half the effort) for eating, oral hygiene, and upper body dressing and bed mobility and required substantial/maximal assistance (helper does more than half the effort) for bed mobility, toileting, bathing/showering, lower body dressing, personal hygiene, and sit to stand.</p> <p>During a review of Resident 2's SBAR (Situation Background Assessment Recommendation) Communication Form and progress note dated 1/5/25 indicated Resident 2 had a change in condition of right-hand edema (swelling).</p> <p>During a concurrent interview and record review on 1/14/15 at 4:45 pm with the Director of Nursing (DON), Resident 2's care plans were reviewed. DON verified there was no care plan for the problem of right-hand edema in the resident's record and stated every problem had to have a care plan.</p> <p>During a review of the facility policy and procedures, Care Planning - Interdisciplinary Team reviewed 6/18/24, indicated the care plan is based on the resident's comprehensive assessment and is developed by a care planning/interdisciplinary team.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252</p> <p>Based on interview and record review, the facility failed to ensure one of three residents (Resident 2) was offered a substitute meal as required if the resident consumed less than 50% of the meal.</p> <p>This deficient practice had the potential to result in malnutrition, dehydration, and overall decline in health and medical condition.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record dated 1/14/25, it was indicated that Resident 2 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), muscle weakness, hypertension (high blood pressure), dysphagia (difficulty swallowing), abnormal posture, and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).</p> <p>During a review of Resident 2's History and Physical (H&P), dated 7/19/24 indicated the patient does not have the capacity (ability) to consent, the reason being dementia.</p> <p>During a review of Resident 2's Minimum Data Set (MDS-an assessment tool) dated 10/21/24 indicated the resident had severely impaired cognition (mental action of understanding, reasoning, thinking, judgment, thought) and required partial/moderate assistance (helper does less than half the effort) for eating, oral hygiene, and upper body dressing and bed mobility and required substantial/maximal assistance (helper does more than half the effort) for bed mobility, toileting, bathing/showering, lower body dressing, personal hygiene, and sit to stand.</p> <p>During a concurrent interview and record review on 1/14/15 at 4:45 pm with the Director of Nursing (DON), Resident 2's CNA (Certified Nursing Assistant) Daily Charting Form dated January 2025 was reviewed. The record indicated; for breakfast on 1/4/25, 1/6/25, 1/7/25, 1/8/25, and 1/9/25, lunch on 1/1/25, 1/5/25, 1/6/25, 1/7/25, and 1/9/25, and dinner on 1/2/25 and 1/3/25, the resident's intake was documented as less than 50%, with no substitute offered. The DON verified these entries and stated they should have offered a substitute and documented it.</p> <p>During a review of the facility policy and procedures, Substitutions reviewed 6/18/24 indicated food substitutions will be made as appropriate or necessary.</p> <p>Based on interview and record review, the facility failed to ensure one of three residents (Resident 2) was offered a substitute meal as required if the resident consumed less than 50% of the meal.</p> <p>This deficient practice had the potential to result in malnutrition, dehydration, and overall decline in health and medical condition.</p> <p>Findings:</p> <p>(continued on next page)</p>

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