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	07/22/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to administer medication as ordered by the physician for one of four sampled residents (Resident 1). For Resident 1, the facility failed to administer the metronidazole (antibiotic that treats infection) 500 milligrams (mg., metric unit of measurement, used for medication dosage and/or amount) as ordered by the physician. This deficient practice resulted in Resident 1 not given one dose of the metronidazole 500 mg. and had the potential for Resident 1's infection to worsen. During a review of the admission Record indicated the facility admitted Resident 1 on 1/30/25 with diagnoses including diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and pressure ulcer (wounds that occur from prolonged pressure on the skin) of the sacral region (lower back). During a review of Resident 1's Care Plan initiated on 2/26/25 indicated Resident 1 was on enhanced barrier precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes) due to gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and pressure injury. The care plan goal indicated to reduce the transmission of the organisms between residents and health care practitioners in the facility. The care plan interventions included administer antibiotic medications as ordered by the physician. During a review of the Minimum Data Set (MDS, resident assessment tool) dated 5/7/25 indicated Resident 1 had severe cognitive impairment. Resident 1 was dependent on toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear and substantial assistance (helper does more than half the effort) with oral hygiene, upper body dressing and personal hygiene. During a review of the Physician Telephone Order dated 7/18/25 at 5:06 p.m. , indicated to give Resident 1 metronidazole 500 mg. one tablet by GT every eight hours for pressure sore on the sacral area. During a review of the Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 7/19/25 at 6 a.m. to 7/22/25 at 6 a.m., indicated Resident 1 was given metronidazole 500 mg. every eight hours. The total of the metronidazole given to Resident 1 should be a total of 10 tablets. During a review of Resident 1's metronidazole bubble pack (medication arranged in individual compartments with one medication for each dosing period sealed with protective bubbles) indicated a total of nine tablets were given to Resident 1 instead of a total of 10 tablets. During a concurrent interview and record review on 7/22/25 at 10:35 a.m., Resident 1's MAR, bubble pack and Antibiotic Drug Record for the metronidazole 500 mg. were reviewed with LVN 2 and LVN 3. LVN 2 stated the metronidazole 500 mg. was started on 7/19/25. The bubble pack and the Antibiotic Drug Record indicated a total of nine tablets of metronidazole were given to Resident 1 instead of a total of 10 tablets. LVN 2 and LVN 3 agreed Resident 1 was not given one dose of the metronidazole 500 mg. During an interview on 7/22/25 at 11:41 a.m., the assistant director of nursing (ADON), stated that when Resident 1 was not given a dose of the metronidazole 500 mg., Resident 1's infection may worsen. During a review of the facility's policy and procedures (P&P) titled Administering Medications reviewed on 1/30/25, the P&P indicated medications shall be administered in a safe and timely manner as prescribed. Medications must be administered in accordance with the orders, including any required time frames.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were kept secure in accordance with professional standards of practice for one of four sample residents (Resident 2). During medication pass observation on 7/22/25 at 9 a.m., the facility failed to ensure Resident 2's medications were not left on top of the medication cart while the medication cart was left unattended. This deficient practice had the potential for other residents and other individuals to easily access the medications on top of the cart for their own. use. During a review of the admission Record indicated the facility admitted Resident 2 on 8/2/23 and readmitted on [DATE] with diagnoses including pneumonia (an infection/inflammation in the lungs) and generalized muscle weakness. During a review of the Minimum Data Set (MDS, resident assessment tool) dated 7/10/25 indicated Resident 2 was cognitively intact. Resident 2 needed substantial assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, moderate assistance (helper does less than the effort) with oral hygiene, upper body dressing and needed supervision with eating. During medication pass observation on 7/22/25 at 9 a.m., licensed vocational nurse (LVN 1) was observed preparing medications for Resident 2. LVN 1 completed preparing the medications and stepped inside Resident 2's room. LVN 1 left the bubble packs (medications arranged in individual compartments with one medication for each dosing period sealed with protective bubbles) on top of the medication cart unattended. During a follow-up interview on 7/22/25 at 10:57 a.m., LVN 1 stated after popping the medications from the bubble pack, place the bubble packs back inside the medication cart and lock the medication cart. LVN 1 further stated when stepping away from the cart, .don't leave any medications on top of the medication cart because of safety reasons because other people might steal the medications. During an interview on 7/22/25 at 11:41 a.m., the assistant director of nursing (ADON) stated when stepping away from the medication cart, no medications should be left on top of the cart for safety reasons. During a review of the facility Policy titled Administering Medications reviewed on 1/30/25 indicated during administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or other passing by. During a review of the facility's policy and procedures titled Storage of Medications, reviewed on 1/30/25, the P&P indicated the facility stores all drugs and biologicals in a safe, secure and orderly manner.