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	09/18/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure administration of medication was documented for one of three sampled residents (Resident 1). For Resident 1, the facility failed to document when Resident 1 was given Benadryl (medication used to relieve symptoms of allergies) 25 milligrams (mg., metric unit of measurement, used for medication dosage and/or amount) orally on 9/18/25.This deficient practice had the potential for medication error and medication duplication to Resident 1. During a review of the admission Record, indicated the facility admitted Resident 1 on 1/31/25 and re-admitted on [DATE] with diagnoses including generalized muscle weakness, hypertension (high blood pressure) and dementia (a group of thinking and social symptoms that interferes with daily functioning).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/14/25, the MDS indicated Resident 1 had intact cognition (participant has sufficient judgement, planning organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). 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 9/25 indicated an order to give Resident 1 Benadryl 25 mg. one tablet by mouth every four hours as needed for itchiness for 14 days. The box for 9/18/25 was not signed out as given. During a concurrent observation and interview on 9/18/25 at 8:47 a.m. with Registered Nurse Supervisor (RNS 1), in Resident 1's room, RNS 1 stated there is a medication cup with Benadryl on top of Resident 1's table. Resident 1 was observed taking the medication cup from RNS 1 and Resident 1 swallowed the Benadryl. During a follow-up interview on 9/18/25 at 11:49 a.m., RNS 1 stated she did not document when Resident 1 was given the Benadryl. RNS 1 further added documentation of the Benadryl should be done at the time the Benadryl was given and taken by Resident 1. During a review of the facility's policy and procedures (P&P) titled Administering Medications reviewed on 1/30/25 indicated the individual administering the medication must initial the resident's Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) after giving each medication and before administering the next ones. As required or indicated for a medication, the individual administering the medication will record in the resident's medical record that included: a. the date and time the medication was administered.b. the dosage.c. the route of the administrationd. any complaints or symptoms for which the drug was administerede. the signature and title of the person administering the drug.

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	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple Park Convalescent Hospital	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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a physician order before administering a medication to one of three sampled residents (Resident 1). For Resident 1 the facility failed to:1. Obtain a physician order prior to the administration of Benadryl tablet (medication used to relieve symptoms of allergies) 25 milligrams (mg., metric unit of measurement, used for medication dosage and/or amount) orally. 2. Ensure the Benadryl 25 mg. tablet was not left at Resident 1's bedside table unattended.These deficient practices had the potential to result in harm to Resident 1 and other residents from inappropriate and unsafe medication administration.During a review of the admission Record, indicated the facility admitted Resident 1 on 1/31/25 and re-admitted on [DATE] with diagnoses including generalized muscle weakness, hypertension (high blood pressure) and dementia (a group of thinking and social symptoms that interferes with daily functioning).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/14/25, the MDS indicated Resident 1 had intact cognition (participant has sufficient judgement, planning organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). During a concurrent observation and interview on 9/18/25 at 8:05 a.m. with Resident 1, a medicine cup with one pink pill was observed on Resident 1's bedside table. Resident 1 stated she complained of itching, and she requested licensed vocational nurse (LVN 1) for Benadryl. During a concurrent observation and interview on 9/18/25 at 8:47 a.m. with Registered Nurse Supervisor (RNS 1), in Resident 1's room, RNS 1 stated there is a medication cup with Benadryl on top of Resident 1's table. RNS 1 stated, when LVN 1 brought the Benadryl to Resident 1, LVN 1 should observe Resident 1 take the Benadryl to ensure that Resident 1 had taken the Benadryl. Resident 1 was observed taking the medication cup from RNS 1 and swallowed the Benadryl. During a follow-up interview on 9/18/25 at 11:49 a.m., RNS 1 confirmed there was no physician order for the Benadryl that was given to Resident 1. RNS 1 stated a physician's order for the Benadryl is needed before administering the Benadryl to Resident 1. During an interview on 9/22/2025 at 8:28 a.m., LVN 1 stated Resident 1 complained of itching on 9/19/25. LVN 1 stated she handed the Benadryl to Resident 1 without observing Resident 1 take the Benadryl. LVN 1 stated she did not check for Benadryl order before giving the medication. LVN 1 stated, She had an order, I think. That was my mistake, I did not check the order. LVN 1 stated it is important to check physician orders to prevent medication errors. LVN 1 stated not checking the physician order may result in giving the wrong medication, or wrong dose, or result in giving medication Resident 1 may be allergic to. LVN 1 stated it is important to check Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) and verify medication orders before giving the Benadryl to Resident 1 for safety. During a review of facility's policies and procedure (P&P) titled Administering Medications, reviewed on 1/30/25, the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed. The same Policy indicated medications must be administered in accordance with the orders, including any required time frame.