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	04/15/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a significant change in condition was promptly reported to licensed nursing staff for one of three residents reviewed (Resident 2), when Certified Nursing Assistant 1 (CNA) did not report a resident's cough on 4/11/2026 for approximately four (4) days.This failure had the potential to delay assessment, diagnosis, and treatment, placing Resident 2 at risk for worsening condition.During a review of Resident 2's admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnosis of acute bronchitis (the temporary inflammation of the airways in the lungs, typically caused by viruses), and Chronic Obstructive Pulmonary Disorder (COPD -lung disease causing restricted airflow and breathing problems).During a review of Resident 2's Minimum Data Set (MDS- resident assessment tool), dated 2/5/2026, indicated, Resident 2 had intact cognitive skills for daily decision making. The MDS indicated Resident 2 required partial assistance from staff for oral hygiene, toileting, showering, upper and lower body dressing, personal hygiene, and putting on taking off footwear. Resident 2 required partial assistance from staff to roll left and right, sit to lying, sit to stand, and sitting on side of bed. The MDS indicated Resident 2 required supervision for eating.During a concurrent observation and interview on 4/15/2026 at 10:30 AM with Resident 2, in Resident 2's room, Resident 2 sat up in her bed unassisted and began to cough forcefully, unable to speak. After coughing persistently for about 30 seconds, Resident 2 stated she's had the cough for a few weeks and believed she was secreting green mucus on 4/14/2026. Resident 2 stated she had been hospitalized a few months ago for bronchitis and was not sure if this was related. Resident 2 stated she was not getting any treatment for the cough at the moment.During an interview on 4/15/2026 at 10:45 AM with Certified Nursing Assistant 1 (CNA1), the CNA1 stated she first noticed Resident 2 coughing on Saturday 4/11/2026 after she assisted Resident 2 with her shower. CNA1 was aware Resident 2 had gone to the hospital for a persistent cough in January and had returned to the facility feeling better. CNA1 stated she had not reported to a licensed nurse about the cough Resident 2 was experiencing because she thought the licensed nurses were aware.During a concurrent interview and record review on 4/15/2026 at 11:03 AM with the Charge Nurse (CN), the CN verified that Resident 2 had been sent to the hospital for evaluation of a persistent cough on 1/23/2026. The CN confirmed that the Electronic Medical Record (EMR) was the primary and expected location for reviewing and revising Change of Condition as well as verbal reports by staff. The CN stated no one had reported to her about Resident 2 experiencing a new persistent cough. The CN verified on the EMR that Resident 2's new onset cough had not been reported as a change of condition by staff. Review of the electronic medical record (EMR), identified by staff as the facility's primary source of clinical documentation, revealed no evidence that staff had reported new onset of cough for Resident 2 since her last episode in January 2026.During a review of the facility's policy and procedures titled Changes in Resident Condition dated January 2025, indicated changes in resident condition are communicated from shift to shift through the 24 hour report management system. Changes in the resident status that affect the problem, goals, or approaches on resident's care plan are documented as revisions and communicated to the interdisciplinary caregivers.

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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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 2) had a comprehensive care plan that was timely revised, consistently documented, and readily accessible to staff following a significant change in condition requiring hospitalization on 1/27/2026.This failure resulted in Resident 2 lacking a Care Plan listing goals and interventions to address her diagnosis of acute bronchitis (the temporary inflammation of the airways in the lungs, typically caused by viruses) on 1/27/2026 and had the potential to impact the coordination of care and Resident 2's health outcomes.During a review of Resident 2's admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnosis of acute bronchitis (the temporary inflammation of the airways in the lungs, typically caused by viruses).During a review of Resident 2's Minimum Data Set (MDS- resident assessment tool), dated 2/5/2026, indicated, Resident 2 had intact cognitive skills for daily decision making. The MDS indicated Resident 2 required partial assistance from staff for oral hygiene, toileting, showering, upper and lower body dressing, personal hygiene, and putting on taking off footwear. Resident 2 required partial assistance from staff to roll left and right, sit to lying, sit to stand, and sitting on side of bed. The MDS indicated Resident 2 required supervision for eating.During a concurrent observation and interview on 4/15/2026 at 10:30 AM with Resident 2, in Resident 2's room, Resident 2 sat up in her bed unassisted and began to cough forcefully, unable to speak. After coughing persistently for about 30 seconds, Resident 2 stated she's had the cough for a few weeks and believed she was secreting green mucus on 4/14/2026. Resident 2 stated she had been hospitalized a few months ago for bronchitis and was not sure if this was related. Resident 2 stated she was not getting any treatment for the cough at the moment.During an interview on 4/15/2026 at 10:45 AM with Certified Nursing Assistant 1 (CNA1), the CNA1 stated she first noticed Resident 2 coughing on Saturday 4/11/2026 after she assisted Resident 2 with her shower. CNA1 was aware Resident 2 had gone to the hospital for a persistent cough in January and had returned to the facility feeling better. CNA1 stated she had not reported to a licensed nurse about the cough Resident 2 was experiencing because she thought the licensed nurses were aware.During a concurrent interview and record review on 4/15/2026 at 11:03 AM with the Charge Nurse (CN), the CN verified that Resident 2 had been sent to the hospital for a persistent cough on 1/23/2026, and upon her return to the facility from the hospital, Resident 2's Care Plan had not been updated to include new diagnosis of acute bronchitis and respiratory monitoring needs. The CN confirmed that the Electronic Medical Record (EMR) was the primary and expected location for reviewing and revising Care Plans and is the only location she would look to guide her practice when providing care for residents. The CN stated no one had reported to her about Resident 2 experiencing a new persistent cough. The CN verified on the EMR that Resident 2's new onset cough had not been reported as a change of condition by staff. During a concurrent interview and record review on 4/15/2026 at 11:25 AM with the MDS Nurse, the MDS Nurse verified that Resident 2 did not have a Care Plan for acute bronchitis on the EMR after returning from the hospital. The MDS nurse stated Care Plans are revised and updated on the EMR upon arrival from the hospital to list new orders, diagnosis, and treatment. The MDS nurse verified that Resident 2 had a new diagnosis of acute bronchitis upon return to the facility on 1/27/2026 and had new medication orders for an antibiotic (medication to treat infection).Review of the electronic medical record (EMR), identified by staff as the facility's primary source of clinical documentation, revealed no evidence of a revised care plan addressing the new diagnosis of acute bronchitis, respiratory monitoring needs, antibiotic treatment and associated interventions back in January 2026 after Resident 2 returned to the facility from the hospital. The EMR revealed no evidence that staff had reported new onset of cough for Resident 2 since her last episode in January 2026.During an interview on 4/15/2026 at 12:47 PM with the Director of Nursing (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(DON), the DON stated that Care Plans are important because it helps assess interventions needed for monitoring treatment, medications, side effects of medications, monitor pain and respiratory issues. The DON stated any licensed nurse can update the Care Plan upon admission and or readmission from the hospital. The DON stated a Care Plan addressing the condition for Resident 2 was documented on paper. At the time of the initial request and review, the alleged paper Care Plan was not readily available in Resident 2's chart. Staff present during the review reported they had not seen or accessed such documentation. The paper document was later presented after the state surveyor requested and pointed out it's absence from the EMR.During a review of the facility's policy and procedure titled Care Plan-Comprehensive Person-Centered dated January 2025, indicated an individualized Comprehensive Care Plan includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs. Each resident's Care Plan has been designed to incorporate identified problem areas, risk factors associated with identified problems, reflect treatment goals and objectives in measurable outcomes. Identify the professional services that are responsible for each element of care. Care plans are revised as changes in the resident's condition dictate. Care plans are reviewed at least quarterly.