

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 06/08/2026
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one of three sampled Residents (Resident 1), Resident 1 who was assessed as high risk for falls, received adequate supervision and fall prevention interventions to prevent repeated falls on 5/31/2026 and 6/1/2026 by failing to: 1. Reevaluate the resident's fall risk or determine whether current fall prevention interventions required modification following the fall on 5/31/2026 at approximately 11 PM. 2. Update the resident's care plan or implement additional interventions prior to the second fall occurring on 6/1/2026 at approximately 3 -4 AM. As a result, Resident 1 experienced a second fall and sustained injuries to the right eye and right knee requiring hospital evaluation. During a record review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] with diagnoses of dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities), repeated falls, and need for assistance with personal care. During a record review of Resident 1's Fall Risk Evaluation dated 3/24/2026, indicated Resident 1 was high risk for falls due to intermittent confusion, history of 1-2 falls in the past three months, poor vision, balance problems, decreased in muscular coordination, taking 1-2 medications in the last seven days that affect coordination, and present predisposing diseases. During a record review of Resident 1's Care Plan (CP) for Risk for falls, dated 4/13/2026, indicated Resident 1 was at risk for falls related to cognitive impairment, history of falls, and poor safety awareness. The goals of CP included that Resident 1 would demonstrate selective prevention measures, would not sustain a fall, and caregivers would implement strategies to increase safety and prevent falls, and Staff would promptly assess the need of the resident to avoid getting up unassisted. During a record review of Resident 1's Minimum Data Set (MDS- resident assessment tool) dated 4/13/2026, the MDS indicated Resident 1 had impaired cognition (ability to think, remember and reason for daily decision making). Resident 1 required maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with sitting up, lying to sitting on side of bed, chair/bed to chair transfer, repositioning, oral hygiene, toileting, shower bathe, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. Resident 1 was dependent (Helper does all the effort. Resident 1 does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) on staff to wheel herself 150 feet once seated in a wheelchair. Resident 1 required supervision (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) from staff to eat. During a record review of Resident 1's Communication Form, dated 5/31/2026, the Communication Form indicated Resident 1 had a witnessed fall on 5/31/2026 at around 11 PM due to Resident 1 observed to be getting out of her wheelchair multiple times at the nurse's station, and during shift change Resident 1 stood up from her wheelchair and fell and hit her head on a cart at the nurses station. Resident 1 was transferred to the hospital after the accident of the fall. Resident 1 was brought back to the facility on 6/1/2026 at 3 AM. Resident 1 was administered Ativan (Medication used to treat anxiety, insomnia, or sleep (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555019
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