STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055036	A. BUILDING _____ B. WING _____	C 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEALTHCARE CENTER	2625 MAPLE AVE. LOS ANGELES, CA 90011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a Facility Reported Incident (FRI). Facility Reported Incident Number: CA00889909 Representing the Department: Health Facilities Evaluator Nurse: 48429 HFEN One deficiency was identified for the complaint number: CA00889909 (Refer to F655).	F 000	This Plan of Correction (POC) serves as our Credible Allegation of Compliance. The facility will be in substantial compliance on or before 04/18/2024. This plan of correction does not admit guilt to any of the alleged violations nor does this interfere with the right to contest or appeal the alleged violations. A. **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a). Resident 4 chart is reviewed on 04/16/24 by IDON. Per review, resident has been discharged from the facility on 3/15/2024. B. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** a) On 04/16/2024, the IDON reviewed residents admitted since 02/28/2024. Since then, 4 residents were identified to reside in the facility. b) On 04/16/2024, the IDON reviewed all 4 resident's baseline care plans, and were all completed, thereby no other residents were affected by this deficient practice. C. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.**	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21 (b) Comprehensive Care Plans §483.21 (b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.1 0(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656'		

LABORATORY DIRECTOR'S OR PROVIDEa/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement endifg 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 suNey 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.

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F 656	Continued From page 1 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21 (b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop/and or implement a resident specific care plan (a document that outlines the facility ' s plan to provide personalized care to a resident based on the resident ' s needs) for one of four sampled residents (Resident 4) by failing to develop and implement a care plan to monitor and provide interventions for Resident 4 ' s Zyprexa (a medication to treat mental disorders) use. This failure had the potential to result in Resident 4 not being assessed and monitored for the side effects of Zyprexa which included dizziness, constipation, bladder pain, difficulty swallowing, and swelling of hands and feet.	F 656	a. The Admission Baseline Care Plan Log is initiated on 04/16/2024. Completed on 04/16/2024. b) On 04/15/2024, General in-service Provided by IDON regarding Policy and Procedure of Baseline Care Plans to be completed within 48 hours of admission. D. **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** a) The IDON will utilize the Admission Baseline Care Plan Log to review that the base line care plan was initiated on residents admission and review will be conducted within 24-48 hours for admission x 3 months. b) The IDON and or designee will review any findings from the audit tool with the QA committee monthly x 3. E. **Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.** Corrective action is completed on 04/18/2024.	

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F 656	Continued From page 2 Findings: A review of Resident 4 ' s Admission Record indicated the resident was originally admitted to the facility on 11/1/2023, and was readmitted on 2/28/2024, with diagnoses that included polyneuropathy (weakness, numbness, and burning pain in the hands and feet and sometimes to other parts of the body), opioid dependence (reliance on a substance found in certain prescription pain medications or illegal drugs), and paranoid schizophrenia (a pattern of behaviors where a person feels distrustful and suspicious of other people). A review of Resident 4 ' s Minimum Data Set (MOS- a standardized assessment and screening tool) dated 3/5/2024, indicated Resident 4 was cognitively (brain ' s ability to think, read, learn, remember, reason, express thoughts, and make decisions) intact. The MOS indicated Resident 4 was independent with dressing, toilet use and personal hygiene. A review of Resident 4's Order Summary Report dated 2/28/2024, indicated Resident 4 was prescribed Zyprexa 10 milligrams (mg) two times daily for angry outburst related to paranoid schizophrenia. A review of Resident 4 ' s SBAR (situation, background, assessment, and recommendation), dated 3/15/2024, indicated Resident 4 was involved in a resident-to-resident physical altercation with Resident 4 ' s roommate. The SBAR indicated Resident 4 verbalized hearing voices before the incident.	F 656	This serves as our credible allegation of compliance.	

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F 656	Continued From page 3 During a concurrent interview and record review on 3/19/2024 at 11:00 AM with Director of Nurses (DON), Resident 4's care plans dated 2/28/2024 were reviewed. A care plan for Resident 4's Zyprexa was not initiated on 2/28/2024. The DON confirmed no care plan was created on 2/28/2024 for Resident 4's Zyprexa use. The DON stated it wasimportant to have care plans completed to match residents' diagnosis so other disciplines (other facility staff providing care and services) could follow the plan of care. A review of the facility's policy and procedures (P&P) titled "Care Plans - Baseline" revision date of 12/2016, indicated that the facility shall develop a baseline care plan to meet the resident's immediate needs within 48 hours of admission, and the interdisciplinary team would review the healthcare practitioner's orders (example, dietary needs, medications, and routine treatment) for a person-centered care plan.	F 656:		