STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056174	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Wilshire Health Care Cntr	676 S. Bonnie Brae Street Los Angeles, CA 90057

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 43851 Based on observation, interview, and record review, the facility failed to provide protection from sexual (non-consensual sexual contact of any type with a resident, including sexual harassment, sexual coercion, or sexual assault) by facility staff, for one of three sampled residents (Resident 1). Resident 1 alleged sexual abuse by Certified Nurse Assistant (CNA) 1, when CNA 1 touched the resident ' s private parts and held Resident 1's hand on his (the CNA's) private part. This deficient practice resulted in Resident 1 having psychological distress (a state of emotional suffering), was crying and reported feeling afraid, ashamed, anxious and guilty. Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident on 3/15/2024 with the diagnoses including the lack of coordination (impaired balance) and abnormalities of gait (walking pattern) and mobility. A review of Resident 1's History and Physical dated 3/18/2024, indicated the resident was transferred to the facility for physical therapy (care that helps people with physical and functional limitations caused by injury or disease) after suffering a fall on 3/12/2024. The History and Physical further indicated Resident 1 had medical decision-making capacity. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 3/20/2024, indicated the resident was cognitively intact (able to think, understand, and reason). A review of the Nurse Staffing Assignment dated 3/23/2024, indicated CNA 1 was assigned to take care of Resident 1 during the 7 AM to 3 PM shift. According to a review of the Situation, Background, Assessment, and Recommendation (SBAR, a structured communication framework that can help teams share information about the condition of a patient) Communication Form and Progress Note dated 3/25/2024 at 2 PM, the resident was not feeling good and felt weird. The note indicated Resident 1 called Caregiver (CG) 1 around 2 PM on 3/23/2024 and informed CG 1 the assigned CNA touched Resident 1's private parts and held the resident's hand on his (the CNA's) private part. The note indicated Resident 1's family and physician were notified. (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 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Social Services Note dated 3/25/2024 at 5:40 PM, indicated staff were informed Resident 1 wanted to report something that happened on 3/23/2024. The note indicated Resident 1 stated that her CNA improperly touched her private area. The note indicated CNA 1 was no longer at the facility and a psychologist (a mental health professional who uses psychological evaluations and talk therapy to help people learn to better cope with life and relationship issues and mental health conditions) consultation (a meeting with an expert or professional, such as a medical doctor, to seek advice) was scheduled for 5 PM that day. The note indicated Resident 1's emotions and behavior would be continuously monitored for any changes, and indicated support would be provided as needed. A review of Resident 1's Psychotherapy Note dated 3/25/2024, indicated the therapist inquired about the resident' recent sexual abuse allegation. The note indicated the therapist addressed Resident 1's feelings of guilt and shame. The note indicated Resident 1 initially presented as generally calm with a congruent affect (when a mood matches a person ' s behavior) but later became tearful at various points during the session. The note indicated Resident 1 reported sleep disturbance due to frequent urination and distressing dreams. The note indicated Resident 1 was able to revisit the event, fully described related details, and processed associated thoughts and feelings that included guilt, shame, humiliation, anxiety, fear, confusion, butterflies in the stomach, some anxiousness due to intrusive thoughts since the event, and fear of CNA 1. During an interview on 3/27/2024 at 8:53 AM, Resident 1 stated the incident happened on Saturday 3/23/2024 around 1 PM to 2 PM. Resident 1 stated she had to have her incontinent brief changed and called her CNA who was male. Resident 1 stated CNA 1 told her to lie back down and then started to touch her vagina and move his hand in circles. Resident 1 stated she was frightened. Resident 1 stated CNA 1 then took her hand and put it over his private area and she felt CNA 1's private area getting bigger. Resident 1 stated she tried to move her hand, but CNA 1 grabbed it and placed it back on his private area. Resident 1 stated she said 'no' three times. Resident 1 stated afterwards CNA 1 started massaging her shoulders. Resident 1 stated she was scared because the CNA's usually just change her incontinent brief and leave; but this CNA stayed a while. Resident 1 stated she did not know who to talk to and remembered she had a previous caregiver at home. Resident 1 stated she called the caregiver and told them what happened. Resident 1 stated the caregiver came to the facility on Monday 3/25/2024. Resident 1 stated she did not remember the CNA's name, but indicated the CNA was tall, wearing black scrubs, and had a little darker skin. Resident 1 stated she saw CNA 1 again on Monday, which made her scared. Resident 1 was observed crying and tearful. Resident 1 stated she was afraid and indicated she was worried she would get moved from the facility and not get taken to activities, because she told someone what happened. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/27/2024 at 11:50 AM, the Social Services Director (SSD) stated she heard of what happened on 3/25/2024 at 2 PM, that Resident 1 was crying, and was afraid and ashamed that she could not talk about the incident the day it happened. The SSD stated Resident 1's caregiver from home encouraged her to tell the facility about what happened. The SSD stated she along with the Administrator, Director of Staff Development (DSD), and Activities gathered in Resident 1's room. The SSD stated Resident 1 indicated the incident happened on Saturday 3/23/2024 during the 7 AM to 3 PM shift. The SSD stated Resident 1 could not remember the exact time but remembered the CNA was on the morning shift, because he left after 3 PM. The SSD stated Resident 1 indicated CNA 1 came to the resident's room to change her incontinent brief; and once he opened the incontinent brief the CNA put his finger on the resident ' s private area. The CNA then took the resident ' s hand and put it on his private area. The CNA stated Resident 1 indicated she said 'no' three times, but he kept rubbing the resident ' s private area. The SSD stated Resident 1 was crying and was afraid her son might get upset if he found out. The SSD stated Resident 1 stated she never had any similar experiences in the past. The SSD stated Resident 1 felt ashamed. During an observation on 3/27/2024 at 1:09 PM, the facility's surveillance video was viewed. The video revealed on 3/23/2024 at 2:05 PM, CNA 1 entered Resident 1's room and put on gloves. At 2:06 PM CNA 1 was observed pulling the curtain around Resident 1's bed. At 2:07 PM, CNA 1 was observed coming out from behind the curtain of Resident 1's bed and exiting the resident's room. At 2:16 PM, CNA 1 was observed re-entering Resident 1's room. At 2:19 PM, CNA 1 was observed pulling the curtain around Resident 1's bed. At 2:20 PM CNA 1 was observed coming out from behind the curtain of Resident 1's bed not wearing gloves. At 2:25 PM CNA 1 was observed entering Resident 1's bathroom by himself, was observed in the bathroom for a few minutes, and then observed leaving Resident 1's room. On 3/27/2024 at 3:30 PM, during a telephone interview, CNA 1 stated he did not touch Resident 1's vagina. CNA 1 stated he did not make Resident 1 touch his private area. CNA 1 stated he was only doing his job to clean Resident 1. During a telephone interview on 3/28/2024 at 11:39 AM, CG 1 stated she knew Resident 1 for over two years and knew the resident before she was transferred to the facility. CG 1 stated Resident 1 called her on Saturday 3/23/2024 and informed her that a CNA touched the resident ' s private area when he was changing the resident ' s incontinent brief. CG 1 further stated Resident 1 informed her the CNA also made the resident touch his private area. CG 1 stated she went to the facility on Monday 3/25/2024 and Resident 1 got sacred when she saw CNA 1. CG 1 stated Resident 1 felt very uncomfortable and that was when she informed the facility staff about what had happened between Resident 1 and CNA 1. During an interview on 3/28/2024 at 12:02 PM, the DSD stated CNA 1 was from the registry and after the allegation, CNA 1 was asked to leave the facility. The DSD stated CNA 1 would not be returning to the facility. During an interview on 3/28/2024 at 2:58 PM, the Administrator stated Resident 1 explained that CNA 1 came into her room and touched her vagina area. The Administrator stated CNA 1 was asked to make a statement and leave the facility. The Administrator stated CNA 1 would not be allowed back in the facility and that Resident 1 was cognitively intact. The Administrator stated Resident 1's story never changed when she told it to the facility staff and to the police officers. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's Follow-Up Investigation Report dated 3/29/2024, indicated on Monday 3/25/2024 around 2:15 PM, indicated the Administrator asked the SSD to ensure Resident 1 was safe with frequent visits for the next few days. The report indicated CNA 1 was moved away from Resident 1, was asked to make a statement, and was asked to leave the facility. The report indicated the psychologist came to meet with Resident 1 the same day. The report indicated the police came to the facility at 5:30 PM and took a statement from Resident 1. The report indicated Resident 1 told the police officers the same story. The report further indicated Resident 1 told the psychologist the same story. The report indicated the facility could not disregard Resident 1's allegations and safety concerns because the resident was alert and oriented. The report indicated the facility would continue to provide room visits with Resident 1 to reinforce safety. The report further indicated CNA 1 was no longer allowed in the facility. A review of the facility's policy and procedure titled, Abuse and Neglect Prohibition Policy, reviewed 6/2023, indicated it was the facility's policy to prohibit abuse, mistreatment, neglect, involuntary seclusion of all residents. The purpose of the policy was to ensure facility staff were doing all that was within their control to prevent occurrences of abuse, mistreatment, neglect, involuntary seclusion, injuries of unknown origin, and misappropriation of property for all residents. Abuse was defined as the willful infliction of physical pain, injury, or mental anguish, or the willful deprivation by a caretaker of services which were necessary to maintain physical or mental health including the following. Sexual abuse was non-consensual sexual contact of any type with a resident, including sexual harassment, sexual coercion, or sexual assault.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 43851 Based on interview and record review, the facility failed to ensure competent staff and provide abuse training, per facility policy, to Certified Nursing Assistant (CNA) 1, who was accused of sexually abusing Resident 1. CNA 1 did not receive Abuse Training while employed at the facility for several months. This deficient practice caused an increased risk of sexual abuse to Resident 1 and other facility residents. Findings: A review of the facility's in-services dated 2/3/2023, titled, Elder Abuse: Mandated Reporter, at 2 PM, did not indicate CNA 1 attended the in-service. A review of the facility's in-services titled, Abuse: Signs of Suspected Abuse/Unknown Injuries, dated 4/15/2023 at 2 PM, did not indicate CNA 1 attended the in-service. A review of the facility's in-services titled, Abuse: Mandated Reporting-Reporters, dated 5/2/2023, did not indicate CNA 1 attended the in-service. A review of the facility's in-service titled, Elder Abuse dated 11/15/2023, did not indicate CNA 1 attended the in-service. A review of the facility's in-service titled, Reporting Unusual Occurrences dated 3/1/2024, did not indicate CNA 1 attended the in-service. On 3/27/2024 during the employee file review, the facility did not have an employee file for CNA 1 to indicate date of hire or appropriate competencies or skill sets. A review of Resident 1's Admission Record indicated the facility admitted the resident on 3/15/2024 with diagnoses including lack of coordination (impaired balance) and abnormalities of gait (walking pattern) and mobility. A review of Resident 1's History and Physical dated 3/18/2024, indicated 1 had medical decision-making capacity. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 3/20/2024, indicated the resident was cognitively intact (able to think, understand, and reason). A review of the facility's Nurse Staffing Assignment dated 3/23/2024, indicated CNA 1 was assigned to take care of Resident 1 during the 7 AM to 3 PM shift. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a review of the Situation, Background, Assessment, and Recommendation (SBAR, a structured communication framework that can help teams share information about the condition of a patient) Communication Form and Progress Note dated 3/25/2024 at 2 PM, Resident 1 was not feeling good and felt weird. The note indicated Resident 1 called Caregiver (CG) 1 around 2 PM on 3/23/2024 and informed CG 1 the assigned CNA touched Resident 1's private parts and held the resident's hand on his (the CNA ' s) private part. The note indicated Resident 1's family and physician were notified. During an interview on 3/27/2024 at 8:53 AM, Resident 1 stated the incident happened on Saturday 3/23/2024 around 1 PM to 2 PM. Resident 1 stated she had to have her incontinent brief changed and called her CNA who was male. Resident 1 stated CNA 1 told her to lie back down and then started to touch her vagina and move his hand in circles. Resident 1 stated she was frightened. Resident 1 stated CNA 1 then took her hand and put it over his private area and she felt CNA 1's private area getting bigger. Resident 1 stated she tried to move her hand, but CNA 1 grabbed it and placed it back on his private area. Resident 1 stated she said 'no' three times. Resident 1 stated she was scared because the CNA's usually just change her incontinent brief and leave; but this CNA stayed a while. Resident 1 stated she did not know who to talk to and remembered she had a previous caregiver at home. Resident 1 stated she called the caregiver and told them what happened. Resident 1 stated she did not remember the CNA's name, but indicated the CNA was tall, wearing black scrubs, and had a little darker skin. Resident 1 was observed crying and tearful. During an observation on 3/27/2024 at 1:09 PM, the facility's surveillance video was viewed. The video showed on 3/23/2024 at 2:05 PM, CNA 1 entered Resident 1's room and put on gloves. At 2:06 PM CNA 1 was observed pulling the curtain around Resident 1's bed. At 2:07 PM CNA 1 was observed coming out from behind the curtain of Resident 1's bed and exiting the resident's room. At 2:16 PM CNA 1 was observed re-entering Resident 1's room. At 2:19 PM CNA 1 was observed pulling the curtain around Resident 1's bed. At 2:20 PM CNA was observed coming out from behind the curtain of Resident 1's bed not wearing gloves. At 2:25 PM CNA 1 was observed entering Resident 1's bathroom by himself, was observed in the bathroom for a few minutes, and then observed leaving Resident 1's room. On 3/27/2024 at 3:30 PM, during a telephone interview, CNA 1 stated he did not touch Resident 1's vagina. CNA 1 stated he did not make Resident 1 touch his private area. CNA 1 stated he was only doing his job to clean Resident 1 and that his registry agency did not provide him with abuse training. CNA 1 stated he had been coming to the facility to work for months. CNA 1 stated the facility did not provide him with abuse training during his orientation. CNA 1 stated sometimes the facility would give information on abuse prevention and reporting but could not specify when his last abuse training was. During an interview a concurrent interview and record review on 3/28/2024 at 12:02 PM, the DSD confirmed CNA 1 was from registry and had been coming to the facility for months. The DSD confirmed CNA 1 did not have an employee file. The DSD confirmed CNA 1 did not attend the abuse in-services dated 2/3/2023, 4/15/2023, 5/2/2023, 11/15/2023, and 3/1/2024. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review on 3/28/2024 at 2:25 PM, the DSD stated registry staff were not provided with formal abuse training when they come to the facility because they were not employees on the facility's payroll. The DSD stated the registry staff were usually provided abuse training by their agency. The DSD reviewed the facility's policy and procedure titled, Abuse and Neglect Prohibition Policy, dated 6/2023 and the Master Staffing Agreement dated 10/25/2018. The DSD then stated the Master Staffing Agreement indicated it was the facility's responsibility for compliance with health regulations. The DSD stated the Abuse and Neglect Prohibition Policy indicated all employees should be provided with abuse prevention training. The DSD confirmed CNA 1 was not provided with formal abuse training during orientation to the facility. The DSD stated there was a potential for staff to abuse residents if they were not provided with abuse training. During an interview on 3/28/2024 at 2:36 PM, the Director of Nursing (DON) stated CNA 1 was from registry and indicated he had been coming to the facility for several months. The DON stated the DSD handled abuse training for the staff. During an interview on 3/28/2024 at 2:58 PM, the Administrator stated he was the abuse coordinator and that CNA 1 did not attend the facility's abuse in-services, as all staff should be trained on abuse. The Administrator stated there could be a potential for abuse to occur if staff were not provided with abuse training. A review of the Master Staffing Agreement between the facility and Registry Agency 1 dated 10/25/2018, indicated because the client controls the facility(ies) in which personnel will perform work, client shall be responsible for compliance with Occupational Safety and Health Act and comparable state and local occupational safety and health regulations and standards and shall provide Personnel with a workplace free from occupational hazards. A review of the facility's policy and procedure titled, Abuse and Neglect Prohibition Policy, reviewed 6/2023, indicated the facility would prohibit abuse, mistreatment, neglect, involuntary seclusion, for all residents. The purpose of the policy was to ensure facility staff were doing all that was within their control to prevent occurrences of abuse, mistreatment, neglect, involuntary seclusion, injuries of unknown origin, for all residents. Abuse was defined as the willful infliction of physical pain, injury, or mental anguish, or the willful deprivation by a caretaker of services which were necessary to maintain physical or mental health. Sexual abuse was non-consensual sexual contact of any type with a resident including sexual harassment, sexual coercion, or sexual assault. The policy indicated the Nurse Aid was any individual providing nursing or nursing-related services to residents in a facility. This term may also include an individual who provides these services through an agency or under a contract with the facility but was not a licensed health professional or someone who volunteers to provide such services without pay. The facility's abuse and neglect training program would be provided to all employees through orientation and on-going sessions related to abuse prohibition practices at a minimum of annually, and would include review of abuse and neglect policy; appropriate interventions to deal with aggressive and/or catastrophic reactions of resident; how staff should report their knowledge related to allegations without fear of reprisal, how to recognize signs of burnout, frustration, and stress that may lead to abuse and what constitutes abuse, neglect, facility prohibition and preventing retaliation program for reporting abuse and crimes.