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	07/26/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of eight sampled residents' (Resident 1) food consistency and texture brought in by Resident 1's son on 9/18/23 was allowed and in compliance with her mech soft, finely chopped diet being the food was fed to the resident, and that Resident 1 was assisted, supervised, and monitored for choking when eating. The facility failed to ensure: 1.There was a system in place to check/screen food brought into the facility from outside for consistency and texture to match that which the physician had ordered.2.The physician's order was followed to monitor choking signs and symptoms while feeding the resident.3. Certified Nursing Assistant (CNA 1) did not feed Resident 1 while resident is drowsy on 9/19/2023. Resident 1 who had a diagnosis of dysphagia (difficulty swallowing) oropharyngeal phase (second stage of swallowing when the food goes from the back of the mouth to into the esophagus [tube that connects the throat to the stomach]) and had a choking incident a day prior (9/18/2023). As a result of these failures, Resident 1 had a choking incident at dinner time on 9/18/2023, when the resident was being fed a noodle soup brought in from outside the facility. The second choking incident the next morning on 9/19/2023 during breakfast time which resulted in Resident 1 being found in his room by LVN (Licensed Vocational Nurse) 1 unresponsive (not reacting or moving at all) with no pulse (the number of times the heart beats) and not breathing with egg custard on her bib and inside her mouth. Resident 1 expired at the facility on 9/19/2023.On 7/25/2025 at 4:43 pm, the Department called an Immediate Jeopardy Situation (IJ, a situation in which the provider's non-compliance with one or more requirements of participation has caused, or likely to cause, serious injury, harm impairment, or death to a patient) in the presence of the facility's Administrator (ADM) and the Director of Nursing (DON) and the Director of Staff Development (DSD) related to the failures to ensure Resident 1 received care and services in accordance with Resident 1's physician's orders, care plan, and the facility's policies and procedures. The above failures resulted in Resident 1 being fed outside food on 9/18/2023 for dinner, which was not screened for consistency or texture resulting in a choking incident and not providing assistance with eating, as well as not monitoring for choking the next morning on 9/19/2023 during breakfast as per the physician's orders and care plan.On 7/26/2025 at 5:30 pm, the Department removed the IJ situation in the presence of the ADM, DON, and DSD, while onsite after the surveyors verified the facility's implementation of the IJ removal plan through observation, interview and record review, which included:1.On 9/19/2023 Resident 1 expired.2.On 7/25/2025 at 5:15 pm DON/designee (a person selected or designated to carry out a duty or role) audited the diets of 49 residents with ordered modified diets (eating plan designed to address specific nutritional needs or health conditions) for dinner service to determine any discrepancies in diet order and meal trays - none found.3.On 7/25/2025 at 7:30 pm and outside consultant provided an in-service (ongoing, job-related training provided to staff to enhance their knowledge and skills, ensuring they can deliver high-quality care to residents) to DON and ADM and later the consultant provided in-service training to licensed nurses and nursing assistants in the facility at 10 pm and 11 pm on:Understanding the importance of checking and inspecting food brought in from outside sources for residents. Verifying that outside food aligns with the resident's dietary orders and texture requirements. Identifying the risks of non-compliance with prescribed diets, including choking, aspiration, and medical complications. Communicating effectively with residents and families about dietary restrictions, food safety and associated risks. Providing education to family members who prepare to feed the resident, including proper feeding techniques and the risks associated with feeding. And recognizing and responding appropriately to suspicious or potentially unsafe food items. Also, understanding the importance of education family members about residents' special dietary needs. Identifying appropriate foods and feeding techniques for residents on various special diets (e.g., diabetic, low sodium, pureed and mechanical soft). Effectively communicating dietary restrictions, risks, and safe feeding practices to family members. Demonstrating how to train family members in proper feeding techniques that reduce risks such as choking and aspiration. Documenting education provided and family member understanding in resident records.4.On 7/25/2025 at 10 pm, ADM and DON created Log for Visitors who bring in food from the outside. The log included name of the resident, visitor/family member who is visiting, what food was brought/texture, Education training column if done, and/or modified and last column will have nurse initial to confirm and/or provide comment if necessary.5.On 7/26/2025 at 10:45 am, DSD created new sign was posted in English and Korean at front door and garage entrance for visitors with outside food to go