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	08/06/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to include the resident's next of kin (NOK) during the care plan conference for one of four sampled residents (Resident 2). For Resident 2, the facility failed to include Resident 2's NOK during the care plan meeting on 8/1/25.This deficient practice resulted in Resident 2 and Resident 2's 's NOK's not given their right to participate in the care planning for Resident 2.Findings:During a review of the admission Record indicated the facility admitted Resident 2 on 12/24/18 and readmitted on [DATE] with diagnoses including heart failure (when the heart muscle doesn't pump blood as well as it should) and lack of coordination. During a review of the Minimum Data Set (MDS, resident assessment tool) dated 7/16/25 indicated Resident 2 was cognitively intact. Resident 2 was dependent with staff on putting on/taking off footwear, substantial assistance (helper does more than half the effort) with lower body dressing, toileting hygiene, moderate assistance (helper does less than half the effort) with upper body dressing, personal hygiene and needed supervision with eating and oral hygiene. During a review of Resident 2's Care Plan initiated on 8/1/24 and revised on 2/19/25 indicated Resident 2 prefers family or significant other involved in her care. The Care Plan goal indicated facility will accommodate Resident 2's needs and preferences. The Care Plan intervention included to involve the family and significant others as needed to determine preferences. During a review of the Care Conference Interdisciplinary Team (IDT) Meetings dated 8/1/25 at 10:15 a.m., indicated Resident 2 attended the care conference meeting. There was no documentation that indicated Resident 2's NOK was invited. During a concurrent interview and record review on 8/6/25 at 8:34 a.m., Resident 2's Care Conference IDT dated 8/1/25 was reviewed with the director of staff development (DSD). DSD stated a care conference was held on 8/1/25 but there was no documentation that indicated Resident 2's NOK was notified or invited to the care conference. During an interview on 8/6/25 at 9:21 a.m., registered nurse (RN MDS) stated Resident 2's care conference was done on 8/1/25. RN stated Resident 2's NOK was invited but the NOK was busy at work and was unable to attend the care conference. RN stated she did not document that the NOK was invited and the reasons why Resident 2's NOK was unable to attend. During a review of the facility's policy and procedures (P&P) titled Documentation Guidelines reviewed on 1/29/25, the P&P indicated promptly record as the events or observations occur complete, concise, descriptive, factual and accurately describe services provided to/for the resident. During a review of the facility's P&P titled Care Plan Conference reviewed on 1/29/25, the P&P indicated, it is the policy of the facility to provide each resident, resident's family, surrogate or representative a medium to hold a care conference to meet and discuss the progress, needs and goals of care. The same Policy indicated the facility will encourage residents, surrogates or representatives and families to participate in care planning to include their attendance at the care planning conference.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the residents and/or their responsible party (RP) of room change for one of four sampled residents (Resident 1). For Resident 1, the facility failed to:1.Notify Resident 1's RP before moving Resident 1 to another room on 2/7/25, 2/10/25, 3/4/25 and 3/26/25.2.Provide a written notice including the reason for room change before moving Resident 1 to another room. 3. Document in Resident 1's medical record the room change and the notification of Resident 1's RP. These deficient practices resulted in Resident 1 and Resident 1's RP not given their right to know before the room changes occur. During a review of the admission Record indicated the facility admitted Resident 1 on 9/20/24 and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) and anxiety disorder. During a review of the Minimum Data Set (MDS, resident assessment tool) dated 6/27/25 indicated Resident 1 had moderately impaired cognitive skills. Resident 1 needed maximal assistance (helper does more than half the effort) with shower/bath, moderate assistance (helper does less than half the effort) with toileting hygiene, upper/lower body dressing, putting/taking off footwear, personal hygiene and supervision with eating and oral hygiene. During a review of Resident 1's Census indicated Resident 1 was in Room A on 10/15/24. Resident 1's Census indicated Resident 1 was moved to another room on the following dates:2/7/25 - From Room A to Room B2/10/25 - From room B to Room C3/4/25 - From Room C to Room D3/26/25 - From Room D to Room E During an interview on 8/5/25 at 1:28 p.m., the director of staff development (DSD) stated before changing rooms, Resident 1's RP should be notified and obtain consent before moving Resident 1 to another room. DSD stated she was unable to find documentation that Resident 1's RP was notified before Resident 1 was moved to another room. During an interview on 8/5/25 at 1:55 p.m., the social worker (SW) stated Resident 1's RP was notified prior to moving Resident 1 to another room. SW stated she keeps a binder for the room changes. SW stated she did document the room changes in Resident 1's medical record. During a follow-up interview, the SW stated she does not provide written notice to Resident 1 or Resident 1's RP before the room changes. SW further added the notification was done through text messages. During a review of the facility's policy and procedures (P&P) titled Room Change/Roommate Assignment reviewed on 1/29/25, the P&P indicated prior to changing a room or roommate assignment, all parties involved in the change/assignment (e.g. residents and their representatives (sponsors) will be given advance notice of such change. The same P&P indicated information regarding transfers will be documented in the resident's medical record.