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	05/15/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a comprehensive care plan for one of three sample residents (Resident 1). This deficient practice had the potential to result in delay of nursing care and medical interventions causing Resident 1's condition to worsen and possible hospitalization. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was readmitted on [DATE] (original admission date 10/21/2025). With diagnoses including but not limited to dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), overactive bladder (uncontrolled urge to urinate). During a review of Resident1's Minimum Data Set (MDS- a resident assessment tool), dated 4/23/2026, the MDS indicated Resident 1 had a brief interview for mental status(BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 2 (severe problems with thinking and memory) and required assistance from the nursing staff with bathing and toileting. During a review of Resident 1's History and Physical (H&P - document detailing a patients current and past medical history), dated 5/4/2026, the H&P indicated Resident 1 does not have the capacity to understand and make decisions. Resident 1 has an assigned surrogate as the decision maker (Family 1).During a review of Resident 1's nursing progress notes, dated 1/1/2026, the nursing progress note indicated Resident 1 experienced three episodes of watery, yellowish, loose stool. Resident 1's physician was notified on 1/1/2026. During a review of Resident 1's care plan (CP - a document that outlines a patients specific health need and the steps nurses will take to address such needs), dated 4/3/2026, the CP indicated a long-term CP of Risk for Constipation with a goal of Resident will pass a soft formed stool. The CP indicated two revision dates, on 2/21/2026 and 4/3/2026, for episodes of loose bowel movement (BM). The interventions for the CP indicated give lactulose (a laxative used to treat chronic constipation) by mouth one time a day for constipation, hold if loose stool. The CP indicated two revisions to interventions, hold for loose stool on 3/22/2026, and hold due to loose stool for 10 days on 4/10/2026.During a review of Resident 1's lab results, dated 4/4/2026, the lab results indicated a positive result for clostridium difficile (C. Diff - highly contagious bacterial infection in the large intestine that causes severe watery diarrhea) bacteria in the resident's stool sample. During an interview on 5/14/2026, at 1:45p.m. with Registered Nurse Supervisor (RNS), the RNS stated, care plans are done upon admission by MDS. The MDS develops long-term care plans. The short-term care plans or the change of condition is developed by the RNS, Charge Nurse (CN), or Licensed Vocational Nurse (LVN). The RNS stated if a resident has a new diagnosis such C. Diff the resident's medical chart must reflect a new CP specific to that diagnosis. The RNS stated a CP for C. Diff cannot be under a general CP like diarrhea. The RNS stated, C. Diff needs a specific CP in order to have specific goals and interventions that are unique to C. Diff. During an interview on 5/15/2026, at 11:42a.m. with Director of Nursing (DON), the [NAME] stated that all residents must have CP's initiated upon admission and as needed with any change of condition. The DON stated the baseline care plans are done within the first 48hrs. If a resident has special needs or upon a change of condition, the nurse must develop a care plan immediately to ensure that the condition is resolved and (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

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	05/15/2026

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	improves. The DON stated if the CP is not developed the residents condition may worsen due to delay in care. The DON stated there is no CP for C. Diff in Resident 1's medical chart, it is incorporated in the constipation and Small Bowel Obstruction care plan; this can cause some confusion for the nursing staff since the interventions are completely different. The DON stated it can cause the residents diarrhea to worsen and can lead to dehydration, malnutrition, altered mental status, and hospitalization. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Plan of Care, dated 6/2025, the P&P indicated the facility will implement a comprehensive plan of care that will maintain the residents' highest practicable physical, mental and psychosocial well-being. The comprehensive plan of care will address the residents' individual needs.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer/hold medications per physicians' orders for one of three sampled residents, (Resident 1). This deficient practice had the potential to worsen Resident 1's condition, placing them at risk for electrolyte (essential minerals) imbalance, dehydration (a condition where the body loses more fluids that it takes in), hospitalization and death. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was readmitted on [DATE] (original admission date 10/21/2025). With diagnoses including but not limited to dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), overactive bladder (uncontrolled urge to urinate). During a review of Resident1's Minimum Data Set (MDS- a resident assessment tool), dated 4/23/2026, the MDS indicated Resident 1 had a brief interview for mental status(BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 2 (severe problems with thinking and memory) and required assistance from the nursing staff with bathing and toileting. During a review of Resident 1's History and Physical (H&P - document detailing a patients current and past medical history), dated 5/4/2026, the H&P indicated Resident 1 does not have the capacity to understand and make decisions. Resident 1 has an assigned surrogate as the decision maker (Family 1).During a review of Resident 1's nursing progress notes, dated 1/1/2026, the nursing progress note indicated Resident 1 experienced three episodes of watery, yellowish, loose stool. Resident 1's physician was notified on 1/1/2026, order to hold lactulose (medication that treats constipation) /senna (medication that treats constipation) if pt continues to have diarrhea, continue to monitor closely. During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 1/2026, the MAR indicated lactulose was administered on 1/1/2026, and on 1/2/2026 after having multiple loose stools.During an interview on 5/14/2026, at 1:45p.m. with Registered Nurse Supervisor (RNS), the RNS stated, if someone is having diarrhea laxatives or stool softeners cannot be given. If a resident is experiencing loose stool all laxatives must be held until loose stool stops. The RNS stated according to the MAR in January, Resident 1 received Lactulose and Colace (medication that treats constipation by softening stool) after loose stools began.During an interview on 5/15/2026, at 11:42a.m. with Director of Nursing (DON), the [NAME] stated if a resident is having loose stool, they are not to be given lactulose. Lactulose will make the loose stool worse and places the resident at risk for dehydration, electrolyte imbalance, weight loss, and altered mental status. The DON stated if the physician orders for medications to be held and they are given; it is considered that the physicians orders are not being followed. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 2023, the P&P indicated that medication shall be administered per Physicians orders, and if there is a concern with the medication and the administration of the medication due to a residents condition, the medication will be clarified with pharmacy.