

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Mid-Wilshire Health Care Cntr		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor each resident's preferences, choices, values and beliefs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836</p> <p>Based on observation, interview, and record review, the facility failed to ensure a call light was within reach for one sampled resident (Resident 25). This deficient practice had the potential to result in a delay in meeting the resident's needs for hydration, toileting, and activities of daily living.</p> <p>Findings:</p> <p>A review of the admission record for Resident 25 indicated the resident was readmitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), lack of coordination, and polyoseoarthritis (a degenerative disease that involves more than five joints).</p> <p>A review of Resident 25's Annual Minimum Data Set (MDS - a resident assessment tool) dated 12/25/2024, indicated the resident had severe cognitive impairment (decline in thinking, memory, and reasoning abilities, impacting daily functioning) and needed extensive assistance with bed mobility, dressing, toilet use, personal hygiene, bathing, and transfers.</p> <p>A review of the Side Rail Use Care Plan revised 3/3/2025 indicated Resident 25 was at risk for bedside rail entrapment related to the use of side rails and one of the interventions included to place the call light within reach.</p> <p>On 3/10/2025 at 10:19 AM, during the initial tour of the facility, Resident 25 was observed in her room, lying in bed asleep. Upon further observation, Resident 25's call light was hanging at the end of her bed. The certified nursing assistant (CNA 6) was in Resident 25's room and confirmed the call light was not within the resident's reach. CNA 6 stated she did not know why the call light was not next to Resident 25 and further stated it was important to have the call light within reach so the resident could call for help.</p> <p>During an interview on 3/10/2025 at 1:59 PM, Licensed Vocational Nurse (LVN 4) stated call lights should always be within reach of the resident. LVN 4 stated if a resident was not able to call for help using the call light, then the resident was at risk for falls and would have a delay in receiving care.</p> <p>(continued on next page)</p>

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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<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/10/2025 at 2:18 PM, the Director of Staff Development (DSD) stated all resident's call lights should be placed within reach of the resident so they can call for help. When Resident 25's call light was not easily accessible, then the resident would not be able to get assistance in a timely manner.</p> <p>A review of the facility's policy and procedure (P&P) titled, Answering Call Lights, last revised 6/2024, indicated when a resident was in bed the call light would be placed within easy reach of the resident.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50714</p> <p>Based on interview and record review, the facility failed ensure one of 16 sampled residents (Resident 63) received treatment and care in accordance with professional standards of practice. Resident 63, who had a history of diabetic ketoacidosis (DKA - a serious, potentially life-threatening complication of diabetes that occurs when the body does not have enough insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication], causing it to burn fat for energy instead of sugar, leading to a buildup of harmful acids called ketones in the blood) had abnormally high blood sugar readings, and did not have defined parameters for blood sugar readings to notify the doctor. This deficient practice caused an increased risk in Resident 63 having another episode of DKA.</p> <p>Findings:</p> <p>A review of Resident 63's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including unspecified acidosis (your body fluids have become too acidic, either because you're producing too much acid, not getting rid of enough, or both, leading to a potentially dangerous imbalance) and Type II diabetes (when the body cannot use insulin correctly and sugar builds up in the blood) with ketoacidosis.</p> <p>A review of the Diabetes Mellitus Care Plan, dated 1/28/2025, indicated the goal was for Resident 63 to be free of any signs and symptoms of hyperglycemia (high blood sugar). The care plan intervention indicated facility staff would give diabetes medication as ordered and would monitor / document for side effects and effectiveness. The care plan intervention indicated the facility staff would monitor for signs of hypoglycemia / hyperglycemia such as weakness, dizziness, hunger, pallor (paleness or a loss of color from your normal skin tone), irritability, tremors (shaking or trembling), diaphoresis (excessive sweating), headache, increased thirst, blurred vision, dry skin, change level of consciousness & check finger stick blood sugar and give orange juice or medication as ordered and report to MD.</p> <p>A review of Resident 63's History and Physical (H&P), dated 1/30/2025, indicated the resident had gone to the emergency room with uncontrolled diabetes and was in the early stages of DKA. The H&P indicated Resident 63 had the capacity to understand and make decisions.</p> <p>A review Resident 63's Minimum Data Set (MDS - a resident assessment tool), dated 2/1/2025, indicated the resident's primary language was Korean, had the ability to understand others and had the ability to make himself understood.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Physician's Order Summary Report dated 2/27/2025, indicated Resident 63 was to receive Lantus Solo Star (a long-acting insulin) 100 units/milliliter (ml a unit of measurement used for medication dosage and/or amount) give 25 units subcutaneously (sq - under the skin) at bedtime for diabetes and hold for blood sugar less than 100. Resident 63 had an order for Novolog FlexPen (fast acting insulin) 100 unit/ml - if blood sugar was 0-299 do not give insulin and if blood sugar was 300 or greater give 6 units. The Novolog order also indicated it was to be given every 8 hours if Resident 63's blood sugar was greater than 300 and if his blood sugar was less than 70 to give him four to six ounces of Glucerna (a liquid designed for people with Type II diabetes) and to check the resident's blood sugar in 30 minutes. The Physician's Order Summary indicated Resident 63 to receive Novolog 50% d/w (a liquid injection to treat low blood sugar) intravenously (IV - through a needle or tube inserted into a vein) and to recheck the resident's blood sugar again in 30 minutes. The order did not indicate when the nursing staff should call Resident 63's doctor.</p> <p>A review of the Physician's Progress Note dated 3/3/2025 indicated Resident 63 had been admitted to the hospital on 1/23/2025 with DKA and had a hemoglobin A1C (a blood test that shows your average blood sugar level over the past 2-3 month) of 16.6 (for people without diabetes, a normal HbA1c level is below 5.7%). The progress note also indicated Resident 63's hemoglobin A1C on 2/13/2025 was 14.</p> <p>A review of Resident 63's Medication Administration Record (MAR), dated 3/11/2025, indicated the resident had a blood sugar reading over 500 on the following days:</p> <p>2/3 - 2/5/2025, 2/8, 2/10 - 2/13/2025, 2/16/2025, 2/18 - 2/21/2025, 2/23 - 2/28/2025, 3/1 - 3/6/2025, 3/9/2025, 3/10/2025.</p> <p>According to a review of the American Diabetes Association Website titled, Check Your Blood Glucose (sugar) Diabetes Testing & Monitoring, dated 2025, the target range for A1C was less than 7 and a normal blood sugar reading before meals was between 80 and 130.</p> <p>A review of Resident 63's Progress Notes for February and March 2025, indicated the staff did not document they contacted Resident 63's physician regarding the high blood sugar reading until 3/11/2025. The progress note dated 3/11/2025 indicated the staff received new orders for insulin to treat Resident 63's high blood sugar and to contact Resident 63's doctor if the blood sugar was greater than 400.</p> <p>During a concurrent interview and record review, on 3/11/2025 at 9:25 AM with Licensed Vocational Nurse 2 (LVN 2), Resident 63's MAR, dated 3/11/2025 was reviewed. The MAR indicated Resident 63 had a blood sugar reading over 500 at least 19 times in February 2025 and at least 8 times in March 2025. LVN 2 stated Resident 63 had orders to give 6 units of fast acting insulin if Resident 63's blood sugar was above 500. LVN 2 verified there was no documentation the facility contacted Resident 63's physician to report the high blood sugar readings and verified the facility did not document a change in condition for Resident 63. LVN 2 stated the facility should have contacted Resident 63's physician regarding the high blood sugar readings. LVN 2 stated Resident 63 could have complications due to high blood sugar such as being very thirsty and being dizzy. LVN 2 stated Resident 63 could go into DKA if the facility did not control his blood sugars.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 3/11/2025 at 9:36 AM with Registered Nurse Supervisor 2 (RNS 2), Resident 63's MAR, dated 3/11/2025 was reviewed. Resident 63's MAR indicated the resident had 27 instances where the resident's blood sugar was over 500. The RNS 2 stated Resident 63's doctor was not notified regarding Resident 63's high blood sugar readings. The RNS 2 stated she would contact Resident 63's doctor right away. The RNS 2 stated Resident 63's current insulin regimen (treatment or therapy) was not effective in managing his blood sugars and he was at risk for going back into DKA. RNS 2 stated she could not explain why the facility's staff did not call Resident 63's doctor regarding his consistently high blood sugar readings. The RNS 2 verified the facility did not document a change in condition.</p> <p>During an interview on 3/11/2025 at 10:08 AM with the RNS 2, the RNS 2 stated that the facility's blood glucose machine could only read the blood sugar level up to 599 and not any higher. The RNS 2 stated that because the machine could not register the blood sugar higher than 599, Resident 63's blood sugar could have been higher than 599.</p> <p>During a concurrent interview and record review on 3/11/2025 at 10:19 AM with the Director of Staff Development (DSD), the facility's blood glucose machine's manufacturer's manual, dated 10/2023, was reviewed. The manufacturer's manual indicated if the reading on the blood glucose machine was more than 600 the blood glucose machine would register the reading as HI instead of displaying a number. The manufacturer manual indicated if the blood glucose machine reading was HI, a healthcare professional should be contacted immediately. The DSD accessed the blood glucose machine memory and verified on 3/9/2024 at 8:26 PM, on 3/10/2025 at 8:31 PM, and on 3/6/2025 at 10 PM the blood glucose machine reading was HI. The DSD stated LVN 3 documented the readings on 3/9/2024 at 8:26 PM, on 3/10/2025 at 8:31 PM, and on 3/6/2025 at 10 PM as a reading of 599 and not what the machine actually read as HI.</p> <p>During an interview on 3/11/2025 at 11:16 AM with Resident 63's representative (Family Member 1), FM 1 stated he was aware that Resident 63's blood sugars were running high. FM 1 stated he was not aware the facility had not been contacting Resident 63's doctor about the high readings and was concerned.</p> <p>During an interview on 3/11/2025 at 12:24 PM, LVN 3 stated she documented Resident 63's blood sugar at 599 when the reading on the blood glucose machine showed HI. LVN 3 stated the blood glucose machine did not read past 500. LVN 3 stated she reported the high blood sugar readings for February and March 2025 to the RNS 1. LVN 3 stated she did not document the times she reported Resident 63's high blood sugars to the RNS 1. LVN 3 stated it was important to document the times Resident 63 had high blood sugars so it would be in the resident's record.</p> <p>During an interview on 3/11/2025 at 2:37 PM with the facility's Medical Director (MD), the MD stated the facility nurses should have been communicating with Resident 63's attending physician (medical doctor who is responsible for the overall care of a patient) in regard to his high blood sugar and should have taken immediate action if his blood sugars were over 500. The MD stated the facility nurses should have documented calls to the attending physician and what they did to manage Resident 63's high blood sugars. The MD stated Resident 63 was at risk for DKA if his blood sugars were not under control and running above 500. The MD stated if the blood glucose machine was not reading Resident 63's actual blood sugar and reading HI, the staff should have gotten an order to get a lab draw to assess Resident 63's actual blood sugar. The MD stated he was thankful Resident 63's blood sugar control issues were brought to his attention so the facility could fix the issue moving forward.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/11/2025 at 3:31 PM, RNS 1 stated he could recall LVN 3 notifying him about Resident 63's high blood sugar on 3/5/2025 but the RNS 1 did not document the interaction. When asked about any other instances when nurses had reported Resident 63's high blood sugar, RNS 1 could not recall. The RNS 1 stated the facility did not document when they spoke with Resident 63's attending physician regarding the times Resident 63 had high blood sugars. RNS 1 stated the facility should have documented when they spoke with Resident 63's doctor about Resident 63's high blood sugars.</p> <p>During an interview on 3/12/2025 at 1:09 PM, the MD stated it would have been best for Resident 63's attending physician to indicate defined parameters for when the nurses should call the attending physician regarding Resident 63's high blood sugar readings in regard to the Novolog insulin order dated 1/28/2025. The MD stated even if these instructions to call for high blood sugar readings were missing in the order, the nursing staff should have followed the standard of practice and reported the high blood sugar readings to Resident 63's attending physician.</p> <p>A review of the facility's policy and procedure (P&P) titled, Diabetic Management, dated 6/2024, indicated the policy of this facility is to ensure that each resident's diabetes management is according to current American Diabetes Association's standard. The P&P indicated the purpose of the diabetic management program is to address resident's individual needs with respect to disease management and nutritional approaches and interventions and to monitor and evaluate resident outcome. The P&P indicated the definition of Hyperglycemia= High blood sugar [typically above 200 mg/dl (milligrams per deciliter, a unit used to measure the concentration of a substance, like blood sugar, in a specific volume of fluid such as blood)]. The P&P indicated the definition of ketoacidosis is an emergency condition that can lead to coma or death. It occurs-when there are dangerously high levels of acids (ketones). The P&P indicated staff should Call provider as soon as possible when:</p> <p>a) glucose values are > (greater than) 250 mg/dl (13.9 mmol/L [millimoles per liter - a standard of unit in chemistry that represents a specific number of particles in a liter of fluid]) within a 24-h (24 hour) period,</p> <p>b) glucose values are >300 mg/dl (16.7 mmol/L) over 2 consecutive (back-to-back) days,</p> <p>c) any reading is too high for the glucometer (blood glucose machine), or</p> <p>d) the patient is sick, with vomiting, symptomatic (signs of) hyperglycemia, or poor oral intake (eat or drink).</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836</p> <p>Based on observation, interview and record review, the facility failed to ensure one of two sampled residents (Resident 57) received treatment and services to prevent complications of an enteral feeding tube (g tube, delivery of liquid nutrients through a tube directly into the gastrointestinal tract). Resident 57's enteral feeding tube bag was not changed every 24 hours per the facility's Enteral Feeding Via Pump Administration policy. This deficient practice had the potential to place Resident 57 at risk for infection and gastrointestinal (GI) complications.</p> <p>Findings:</p> <p>A review of the admission record indicated Resident 57 was admitted to the facility on [DATE], with diagnoses including dysphagia (difficulty swallowing), aphasia (a disorder that makes it difficult to speak), dementia (a progressive state of decline in mental abilities), and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements).</p> <p>A review of Resident 57's Quarterly Minimum Data Set (MDS - a resident assessment tool) dated 1/15/2025, indicated the resident had severe cognitive impairment (a significant decline in a person's ability to think, learn, and remember), could not make needs known, and needed maximum assistance with transfer, dressing, eating, toilet use, and personal hygiene. The MDS indicated the resident had a enteral feeding tube, had diagnoses of dysphagia, aphasia, dementia, and Parkinson's.</p> <p>A review of the Physician's Orders dated 1/28/2025 indicated for Resident 57 to receive Jevity 1.5 (a type of therapeutic nutrition) at 45 cc (cubic centimeter-a unit of volume used to measure liquids, such as medication) per hour for 20 hours via (by) pump via g-tube (gastrostomy -a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) to be started at 2 PM until 10 AM.</p> <p>A review of Resident 57's g-tube care plan revised 2/5/2025, indicated the resident was at risk for complications of g-tube feeding such as GI distress (discomfort in the digestive system), blockage, leaking, and infection on the g-tube site. The care plan interventions included to monitor signs and symptoms of GI distress such as nausea, vomiting, diarrhea, abdominal pain, or bloating. The care plan goal was for the resident to be free of signs and symptoms of complications.</p> <p>During an observation of the initial tour of the facility on 3/10/2025 at 10:27 AM in Resident 57's room, a Jevity 1.5 tube feeding bag was observed hanging and connected to the resident. The tube feeding pump was noted to be turned off and the tube feeding bag was dated 3/8/2025 (two days prior).</p> <p>During an interview on 3/10/2025 at 1:59 PM, Licensed Vocational Nurse (LVN 4) stated he did not notice that the date on Resident 57's tube feeding was 3/8/2025. LVN 4 stated that there was an infection risk to the resident since the tube feeding bag and tubing was not changed daily.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/10/2025 at 2:18 PM, the Director of Staff Development (DSD) stated tube feeding bags should be changed every 24 hours and Resident 57 would be at risk for infection and complications such as nausea and vomiting, since the tube feeding bag was not changed regularly.</p> <p>A review of the policy and procedure titled, Enteral Feeding Via Pump Administration, revised on 6/2024, indicated to change administration sets for enteral feedings every 24 hours.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>50296</p> <p>Based on interview and record review, the facility failed to ensure five employees had annual performance evaluations. This failure had the potential to affect the quality of care for the residents.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 3/12/25 at 10 AM with the Director of Staff Development (DSD), five facility employee files were reviewed. Licensed Vocational Nurse (LVN) 2, date of hire (DOH) 4/10/19, LVN 4 - DOH 9/1/22, Certified Nursing Assistant (CNA) 3 - DOH - 4/30/24, CNA 4 / Restorative Nursing Assistant (RNA) - DOH - 4/17/18, and CNA 5 - DOH -8/16/23. The DSD stated these performance evaluations were not done.</p> <p>The DSD stated she did not get trained / updated on performance evaluations and was unaware of the requirement. The DSD stated she did not review the facility policy on performance evaluations and that without performance evaluations the risk could be a delay in care to the residents.</p> <p>During an interview on 3/12/25 at 11:38 AM, the Director of Nursing (DON) stated employee files were required to have an annual performance evaluation. The DON stated she was filling in as Director of Staff Development and should have instructed the current DSD to perform performance evaluations.</p> <p>A review of the facility's policy and procedure (P&P) titled, Annual Performance Evaluation, dated 6/24, indicated each employee would receive an annual performance evaluation review and the documentation of said review would be filed in the employee's human resources file.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>38740</p> <p>Based on observation, interview and record review, the facility failed to ensure the standardized recipes and portion sizes for lunch menu was followed on 3/10/2025 when:</p> <ul style="list-style-type: none"> -Facility failed to ensure staff followed food production recipes for the pureed diet (food that is blended to a pudding consistency, no chewing required) during tray line observation. Twenty-three residents on puree diet did not receive the pureed soybean paste stew and fern salad, they received pureed meat, pureed rice and beans. -Twenty-three residents on the pureed diet received a pureed diet texture that was thin and soupy instead of pureed food that was homogenous, cohesive and had a pudding like consistency. -The menu did not include the therapeutic (diets per physician order for specific disease condition such as kidney disease or high blood sugar) and texture modified diets (these are diets that are altered in texture to accommodate resident chewing or swallowing problems). The menu did not indicate the standard portions and serving guide at each meal. <p>These deficient practices had the potential to result in meal dissatisfaction, decreased nutritional intake and weight loss due to inconsistent portions and increased choking and aspiration risk in residents on pureed diet.</p> <p>Findings:</p> <p>According to the facility lunch menu on 3/10/2025, the following items would serve on regular diet: kimchi (Korean pickles), rice, soybean paste stew (tofu, zucchini and pork), fern salad (Korean dried vegetables) and Sweet Potato.</p> <p>During an observation in the kitchen on 3/10/2025 at 9:30 AM, [NAME] 1 was cutting vegetables and tofu for lunch. [NAME] 1 stated today's main entree was a Korean stew made with pork, tofu and vegetables and served with rice and side salad.</p> <p>During a concurrent interview with [NAME] 1 and Dietary Supervisor (DS) on 3/10/2025 at 9:45 AM, [NAME] 1 stated Residents on pureed diet get something else. The DS stated it was difficult to prepare the Korean menu for the pureed diet, residents on pureed diet receive pureed seasoned meat, pureed mixed vegetables and pureed rice today.</p> <p>During the same interview, the DS stated the menu was updated with new recipes, but it did not incorporate therapeutic diets and texture modified diets in the menu. The DS stated, We don't have portion size and serving guide for the menu and for the pureed diet. We use portion sizes of similar food from the old menu. The DS stated the residents on pureed diet were not receiving pureed soybean paste stew (tofu, zucchini and pork), fern salad (Korean dried vegetables) today.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Mid-Wilshire Health Care Cntr		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation of the tray line service for lunch on 3/10/2025 at 11:50 AM, residents who were on pureed texture diet were served pureed meat (soupy texture), pureed mixed vegetables (soupy texture) and pureed rice (soupy consistency) by [NAME] 1.</p> <p>During a concurrent observation and interview with [NAME] 1 and the DS, the DS stated the pureed food was prepared thin based on resident preference.</p> <p>During a telephone interview with Registered Dietitian on 3/11/2025 at 11 AM, the RD stated she was new in the facility and had not reviewed the menu. The RD stated residents who were on pureed diet should receive the same food as the regular menu. The RD stated the menu should include the therapeutic diets and texture modified diet and should include recipes and portion size and serving guide. The RD stated pureed food texture should be pudding like, pureed food should be cohesive and hold its shape, not too runny and not too dense. The RD stated if the pureed food was too thin it was a potential risk for choking in residents who were on pureed and on thickened liquid. The RD stated she had not provided Inservice to staff regarding texture modified diets or the menu.</p> <p>During an interview with facility Administrator (ADM) on 3/11/2025 at 11:30 AM, the ADM stated the facility would revert back to the old menu which included recipes and portion size and serving guide for all diets to be in compliance. The ADM stated a new RD was in the process to review the new menu to include the therapeutic diets.</p> <p>During an observation of the tray line service for lunch on 3/11/2025 at 12:01 PM, residents who were on pureed diet were served pureed meat (thin texture), pureed corn (thin watery texture) and pureed rice (soupy) instead of Bibimbap (a Korean dish made with rice, beef, and garnished with several types of vegetables served in a bowl) by [NAME] 3.</p> <p>During a concurrent observation and interview, the DS stated residents on pureed diet were not receiving the pureed Bibimbap today.</p> <p>During a review of facility policy titled Menus (Revised 10/2022) indicated, Menus cycles will include standardized recipes, nutrient analysis to ensure that all client nutritional Needs are met.</p> <p>A review of facility policy titled, Menu Planning- Menu Pattern, dated 4/2020 indicated, Written menus will include the following diets-texture modifications: regular, mechanical soft, puree and therapeutic modifications.</p> <p>A review of facility policy titled, Menu Planning-Recipes, dated 4/2020 indicated standardized menu coordinated recipes are available and to be used in meal preparation.</p> <p>A review of facility policy titled, Portion Control, dated 4/2020 indicated, portion control aids in maintaining satisfactory food cost, uniformity of product, ease in food service and helps assure that residents receive a nutritionally adequate diet. Foods are to be served in the portion size designated on the menu.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38740</p> <p>Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and preparation practices in the kitchen when:</p> <ul style="list-style-type: none"> -Meat to be used for lunch preparation was thawing on the kitchen counter. -Ice machine was not maintained in a sanitary manner, the inside compartment of ice machine was dirty and the ice scoop was last cleaned 3/5/2025. -Two gallons of milk and nine individual cups of beverages stored in the reach in refrigerator with no open or use by date. One bag of sliced cheese not in original packaging stored in plastic bag and 14 Individual cups of kimchi stored with no label or date in the walk-in refrigerator. One large container of previously cooked rice stored in the walk-in refrigerator with no label or use by date and six cups of thickened milk beverage stored in the walk-in refrigerator with date of 3/6/2025 exceeding storage period for milk. <p>These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness in 63 or 65 residents who received food from the facility.</p> <p>Findings:</p> <p>a. During an observation in the kitchen on 3/10/2025 at 8:30 AM, there was one bag of frozen sliced pork with a date of 2/17/25 and another bag of frozen sliced pork with a date of 2/28/25 stored on the kitchen counter near the food preparation area.</p> <p>During the same observation [NAME] 1 was loading dirty dishes from breakfast service in the dishwashing machine.</p> <p>During an interview on 3/10/2025 at 8:45 AM, the Dietary Supervisor (DS) stated they were down to two staff members this morning and the DS and [NAME] 1 were washing the dishes. The DS stated [NAME] 1 was completing dishwashing task in addition to the cooking.</p> <p>During an interview on 3/10/2025 at 8:50 AM, [NAME] 1 stated thawing should be in the refrigerator for 24 -48 hours and not on the counter to keep the temperature safe. [NAME] 1 stated the meat should stay in the refrigerator until ready to be prepared. [NAME] 1 sated she made a mistake and left the pork on the counter. [NAME] 1 stated the dates on the bag indicated when food was received in the freezer.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility policy titled, Food: Preparation, revised 2/2023 indicated The Dining Services Director/Cooks will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 F. The cook thaws frozen items that requires defrosting prior to preparation using one of the following methods: Thawing in the refrigerator, thawing the item in a microwave oven; Completely submerging the item under cold water that is running, cooking directly form frozen.</p> <p>b. During an observation of the facility ice machine on 3/10/2025 at 9 AM, located in the kitchen, a clean paper towel swipe of the ice storage bin ceiling and sides produced pink color residue. The residue was also on the baffle (plastic board that hold the ice from falling out of the ice storage bin).</p> <p>During a concurrent observation and interview with DS on 3/10/2025 at 9:10 AM, the DS stated that the Maintenance Supervisor (MS) cleaned the ice machine on monthly basis. The DS stated the last time the MS cleaned the ice machine was on 2/2/2025 and the ice machine was due for a cleaning. The DS stated the ice machine had pinkish color residue. The DS stated the ice machine scoop was cleaned by kitchen staff twice a week and the last cleaning was on 3/5/25. The DS stated the ice scoop was due for cleaning and the unsanitary scoop and ice bin can contaminate the ice.</p> <p>During an interview on 3/11/2025 at 9:45 AM, the MS stated he did not clean the ice machine on time. The MS stated he did not follow the policy for cleaning and forgot to use a sanitizer for cleaning.</p> <p>A review of ice machine cleaning log and policy indicated the ice machine should be cleaned with a sanitizer solution.</p> <p>A review of the facility policy for ice machine titled, Cleaning Ice Machine, undated, indicated, Mix the following solution in a clean bucket: 1 tablespoon of bleach, 1 gallon of water .use a clean cloth and the solution and wipe out the inside of the ice machine.</p> <p>A review of the 2022 U.S. Food and Drug Administration Food Code titled, Equipment Food-Contact Surfaces and Utensils, Code# 4-602.11, indicated, Surfaces of utensils and equipment contacting food that is not time/temperature control for safety food such as iced tea dispensers, carbonated beverage dispenser nozzles, beverage dispensing circuits or lines, water vending equipment, coffee bean grinders, ice makers, and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms.</p> <p>ac. During an observation in the kitchen on 3/10/2025 at 8:30 AM there were two open milk gallons in the reach in refrigerator with no open dates. During the same observation there were signs on the reach in refrigerator that indicated to always date the milk once open. Further observation indicated there were nine cups of milk and juice beverages stored in the reach in refrigerator with no date.</p> <p>During an interview on 3/10/2025 at 8:45 AM, the DS stated staff forgot to date the open gallons of milk. The DS stated when milk or beverage was poured in the cups, it should be labeled and dated. The DS stated she did not know when the milk was poured in cups and would discard the milk. The DS stated the milk in the cups was used in one day.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation in the walk-in refrigerator on 3/10/2025 at 9:30 AM, there was one large container of previously cooked rice with no date. One tray with 14 individual servings of Kimchi (Korean pickles) stored with no label or date and sliced cheese in a plastic bag with no date.</p> <p>During a concurrent observation and interview, the DS stated everything should be dated to know when to discard. The DS stated the left-over rice would be discarded since there was no date on it. The DS stated Cheese not in original packaging should be dated labeled and dated.</p> <p>A review of facility policy titled, Food: Preparation, revised 2/2023 indicated, All refrigerated, ready to eat CS prepared foods that are to be held for more than 24 hours at a temperature of 41 F or less will be labeled and dated with a prepared date (day 1) and a use by date) (day 7).</p> <p>A review of facility policy titled, Food Storage Principles, dated 2020 indicated, Label each package, box can, etc. with the expiration date, date of receipt, or when the items was stored after preparation. A. discard foods that have exceeded their expiration date. discard leftovers foods that have not been used within 48 hours or preparation.</p> <p>A review of the 2022 U.S. Food and Drug Administration Food Code titled, Ready to Eat, Time/Temperature control for safety food, Date Marking, Code#3-501.17, indicated Ready to eat, time temperature control for safety food prepared and packaged by food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed, sold, or discarded.</p>		