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	03/12/2026

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow up on assisting the residents with executing an advance directive (AD - a legal document indicating resident preference on end-of-life treatment decisions) for three of four sampled residents (Resident 2, 5, and 19). This failure had the potential to result in the residents' wishes regarding treatment and care needs not being met. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted on [DATE] with diagnoses including but not limited to atherosclerotic heart disease (the hardening and narrowing of arteries due to plaque buildup), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and high blood pressure. During a review of Resident 2's History and Physical (H&P), dated 12/4/2025, the H&P indicated Resident 2 had the mental capacity to make their own decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), the MDS indicated Resident 2's mental status was moderately impaired and had not executed an AD . During a review of Resident 2's medical record, the AD acknowledgement form, dated 12/2/2025, indicated the AD acknowledgement form indicated Resident 2 wanted to execute an AD. The medical record did not indicate any follow up regarding assisting Resident 2 with AD. During an interview on 3/10/2026 at 11:00 a.m. with Resident 2, Resident 2 stated he wanted to execute an advance directive but has not done so. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was readmitted on [DATE] (original admission 7/13/2022) with diagnoses including but not limited to end stage renal disease (a kidney disease in which the kidneys can no longer function), type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and neuromuscular dysfunction of bladder (a condition where nerve damage or disease causes loss of bladder control). During a review of Resident 5's History and Physical (H&P), dated 6/28/2025, the H&P indicated Resident 5 had the mental capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), the MDS indicated Resident 5's mental status was moderately impaired and had not executed an AD . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's medical record, the AD acknowledgement form, dated 11/7/2025, indicated Resident 5 wanted to execute an AD. The medical record did not indicate any follow up regarding assisting Resident 5 with AD. During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was readmitted on [DATE] (original admission 7/16/2023) with diagnoses including but not limited to DM, vascular dementia (a disorder with reduced blood flow to the brain which cause memory loss and problems with thinking and behavior), and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter waste). During a review of Resident 19's History and Physical (H&P), dated 9/2/2025, the H&P indicated Resident 19 did not have the mental capacity to understand and make decisions. During a review of Resident 19's MDS, the MDS indicated Resident 19's had not executed an AD . During a review o f Resident 19's medical record, the AD acknowledgement form, dated 8/31/2024, indicated Resident 19's Representative wanted to execute an AD. The medical record did not indicate any follow up regarding assisting Resident 19 with AD. During an interview on 3/10/2026 at 11:25 a.m. with Social Services Director (SSD), SSD stated AD acknowledgment forms are done on admission. SSD stated a copy of the AD is placed in the physical chart and uploaded to the electronic health record, if the resident has not executed an AD and wished to execute an AD, there is a lengthy process that involves the resident's family, a notary, and the Ombudsman. SSD stated in the two years working at this facility they have not experienced a resident expressing interest in executing an AD if they have not executed one at time of admission. During a review of the facility's policy and procedure (P&P) titled, Advance Directives, dated February 2017, Reviewed June 2025, the P&P indicated if a resident has not executed an AD and wishes to execute one, the facility can obtain forms for AD from the state nursing facility association or state medical association, and should contact the facility's legal department representative if assistance is needed. P&P indicated the facility will document and maintain record in the clinical record regarding the provision of AD information.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review, the facility failed to provide treatment in accordance with professional standards of practice and established facility protocol for one of five sampled residents (Resident 77) for: a. The use of triple antibiotic ointment (topical antibiotic cream or ointment used to treat skin infections) without a physician order or monitoring every shift for seventy-two-hours for Resident 77. This failure had the potential to result in delayed treatment and compromised resident safety.During a record review of Resident 77's admission record indicated Resident^77 was admitted to the facility on [DATE] with diagnoses of multiple fractures (broken bone) of pelvis (located at the lower part of the trunk), hyperlipidemia (abnormally high levels of fats in the blood), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 77's History and Physical (H&P), dated 3/3/2026, the H&P indicated, Resident 77 has the capacity (ability) to understand and make decisions. During concurrent observation and interview on 3/10/2026 at 9:48 a.m. in Resident 77's room. It was observed Resident 77 walking with a walker from the bed to the door with clean and dry dressing on the back of the left knee. Resident stated that she has a few skin tears that are being treated at the facility. During a review of Resident 77's Order Summary Report (OSR) dated 3/12/2026, the OSR included the following orders: Ordered on 3/5/2026, skin tear on back of left knee on admission: cleanse with normal saline pay dry, apply triple antibiotic ointment (topical medication used to prevent and treat minor skin infections), cover with dry dressing. Ordered on 3/5/2026, skin tear on Right ankle on admission: cleanse with normal saline pat dry, apply triple antibiotic ointment, cover with dry dressing. During an interview and record review on 3/11/2026 at 8:59 a.m. with Treatment Nurse (TXN), Resident 77's Treatment Administration Record (TAR) and physicians' orders were reviewed. TXN stated that Resident 77 has been receiving triple antibiotic ointment for skin tears. TXN stated that no physician order was placed for the triple antibiotic ointment and stated that the order was not required because the Director of Staff Development (DSD) supplied the ointments. TXN further reported that an initial assessment was performed on 03/05/2026; however, they had not yet documented it. TXN stated that treatment staff focus on wound care only and that TXT is not responsible for documenting wound progress. During a concurrent interview and record review on 3/11/2026 at 1:15 p.m. with the Director of Nursing (DON), Resident 77's OSR was reviewed. The DON stated that treatment nurses should assess skin on admission, weekly, and with significant changes; measure and document wounds; follow physician-ordered treatments; and inform physicians of new or worsening wounds. The DON further stated that triple antibiotic ointment is classified as an antibiotic and therefore requires a physician's order and ongoing monitoring. However, Resident 77 did not have an order for the triple antibiotic ointment. The DON emphasized that all antibiotics required a prescription and must be monitored by the nursing staff every shift. The DON stated that the treatment nurse should have contacted Resident 77's physician to obtain an order for the triple antibiotic ointment and documented in the nursing progress notes. During a review of the facility's policy and procedures (P&P) titled, Skin Breakdown, Prevention and Management dated 6/2025, indicated a description of the resident's skin condition will be included in the nursing documentation upon admission and every shift for seventy-two hours. The licensed nurse will notify the independent licensed practitioner for anu sites or area that requires any form of treatment.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to ensure the nursing staffing information was posted and updated daily. This failure resulted in the total number of staff and the actual hours worked by the staff were not readily accessible to residents and visitors. Findings: During an observation on 3/10/2026 at 9:30 a.m. in nurse's station one, the nursing staffing information was not posted the bulletin board. During an observation on 3/10/2026 at 9:31 a.m. in nurse's station two, the nursing staffing information was not posted the bulletin board. During an interview on 3/11/2026 at 10:00 a.m. with the Director of Staff Development (DSD), DSD stated the required staffing information was not posted on a bulletin board for residents, staff, and visitors to view. The DSD stated the census and direct care service hours per patient day (DHPPD) form was kept in a binder at the nurse's station, and a blank form was posted directing individuals to the binder. The DSD stated staffing information should be posted on a bulletin board to ensure accessibility and awareness of staffing hours needed to meet resident care needs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to ensure safe and sanitary food storage practices in the kitchen when:1. A box of bananas were sitting next to an open container labeled Sanitizer disinfectant.2. A plastic container of barley in the dry storage area had no date label.3. A large clear plastic bag filled with chopped cabbage mixed with red pepper flakes with no label or date.These failures had the potential to result in cross contamination (transfer of harmful bacteria from one place to another) and an increased risk of foodborne illness (any illness resulting from eating contaminated or spoiled food) to residents.Findings:During an observation on 3/9/2026 at 7:30 a.m. under the kitchen sink, a box of bananas were sitting next to a small, open red container labeled Sanitizer disinfectant halfway filled with clear liquid.During an observation on 3/9/2026 at 7:35 a.m. in the dry food storage area, a container of barely had no date label.During an observation on 3/9/2026 at 7:40 a.m. in the walk-in refrigerator, a large clear plastic bag filled with chopped cabbage mixed with red pepper flakes had no label or date.During an interview on 3/10/2026 at 12:45 p.m. with the Dietary Supervisor (DS), the DS stated that if food stored in the kitchen is not labeled properly or is placed near sanitation chemicals, the residents are at risk of getting sick.During a record review of the facility's policy and procedure (P&P) titled, Food Storage Principles, dated April 2020, the P&P indicated that food must have a label with the expiration date, date of receipt, or when the item was stored after preparation. The P&P also indicated that cleaning supplies should be stored away from food storage.During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated food shall be stored in a clean, dry location where it is not exposed to splash, dust, or other contamination.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to: 1.Perform hand hygiene for seven of seven sampled residents (Resident 5, 8, 9,19, 22, 59, and 70).2.Wear personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) in enhanced barrier precautions (EBP - infection control strategy requiring staff to use gowns and gloves during high-contact care for residents) rooms for four of four sampled residents (Resident 5, 9, 59, and 70). 3.Prevent cross-contamination during medication administration.4.Implement an effective Infection Prevention and Control Program (IPCP - a program designed to prevent healthcare-associated infections and antimicrobial resistance through education, policies, and surveillance).5.Implement the facility's water plan.These failures had the potential to result in contamination, the spread of infectious diseases, and antibiotic-resistant bacteria to the residents.Findings:1. and 2. During record review of Resident 70's order summary report dated 3/12/2026, the order summary report indicated Resident 70 is on EBP for history of multi drug resistant organism (MDRO - germs that have become resistant to multiple antibiotics). During an observation on 3/9/2026 at 12:14 p.m. in front of Resident 70's room, Certified Nursing Assistant (CNA) 4 entered and exited Resident 70's room without performing hand hygiene (HH) and without putting on PPE.During an observation on 3/10/2026 at 9:37 a.m. in front of Resident 8, 22, and 19's room, RN 2 went in and out of the room to administer medications without performing HH.During an observation on 03/11/2026 at 8:16 a.m. CNA 5 exited EBP room for Resident 5, 9, and 59 without performing hand hygiene (HH) and then entered Resident 8, 19, and 22's room without performing HH.During an observation on 3/11/2026 at 8:36 a.m. LVN 3 administered medications in EBP room for Resident 5, 9, and 59 without wearing a gown and did not perform HH before putting on gloves.During an observation on 3/12/2026 at 2:42 p.m. CNA 5 and RNA 1 were providing resident care in EBP room for Resident 5, 9, and 59 without wearing gowns.3. During an observation on 3/10/2026 at 8:02 a.m. in nurse station one, RN 2 took a plastic basket with an open box of tissues, medicine cups, and cups with tea from the medication cart to multiple resident's rooms. RN 2 placed the plastic basket on multiple residents' bedside tables, including EBP rooms, then returned to medication cart without disinfecting the plastic basket in between use.4. During an interview on 3/11/1026 at 10:20 a.m. with Director of Staff Development (DSD), DSD stated the facility staff do not attend the annual Department of Public Health Infection Prevention and Control (IPC) Training for Skilled Nursing Facilities.During an interview on 3/11/2026 at 10:20 a.m. with DSD and, DSD stated COVID-19 infected residents in transmission-based precautions rooms are advised and encouraged to wear a facemask when they walk out of their rooms or use the patio but they have the right to not wear a mask if they do not want to.During a review of the facility's antibiotic stewardship surveillance record, dated February 2026, the record indicated five of ten resident infections had urinary tract infections (an infection of the bladder/urinary tract). During an interview on 3/11/2026 at 10:20 a.m. with Infection Preventionist Nurse (IPN), IPN stated she did not know how to report infectious diseases to local or state public health authorities.5. During an interview on 3/11/2026 at 1:00 p.m. with Administrator, Administrator stated the facility's water management plan map is not accurate and they do not know where the water comes into the facility.During an interview on 3/11/2026 at 1:00 p.m. with Maintenance Supervisor (MS), MS stated the facility does not follow water management plan to do chlorine water testing.During a review of the facility's policy and procedure (P&P) titled, Scope of Infection Control Program, dated June 2022, the P&P indicated the facility will:1. Follow standard hand hygiene procedures when providing direct resident contact and use PPE to protect residents from cross-contamination.2.Follow standard and transmission-based precautions to prevent the spread of disease.3.Know when and to whom to report communicable diseases or infections.4.Have a system to prevent, identify, report, investigate, and control diseases for all residents.During a review of the facility's policy and procedure (P&P) titled, Infection Control (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveillance dated June 2022, the P&P indicated the IPCP should implement and monitor the facility's compliance with HH, use of PPE, and do routine observations to identify training needs and practice changes.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 31) was monitored for antibiotic use. This failure had the potential to result in severe organ damage and antibiotic resistance to the resident. Findings: During a review of Resident 31's admission Record, the admission Record indicated Resident 31 was readmitted [DATE] (original admission 1/31/2017) with diagnoses including but not limited to type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter waste). During a review of Resident 31's History and Physical (H&P), dated 2/1/2026, the H&P indicated Resident 31 had a history of urinary tract infections (UTI - an infection in the bladder/urinary tract), and was hospitalized with an UTI in February 2025. During a review of Resident 31's Care Plan, dated 12/7/2025, the Care Plan indicated a long-term Care Plan for history of extended-spectrum beta lactamase (ESBL - multi drug resistant bacteria)/UTI with no updated interventions. During a review of Resident 31's physician's orders, dated 2/6/2026, the physician's order indicated an Resident 31 as ordered Macrobid (a type of antibiotic to treat UTI) 100 mg (milligrams) give one capsule by mouth two times a day for UTI for seven days. During a review of Resident 31's physician's order, dated 2/9/2026, the physician's order indicated an order for Macrodantin (a type of antibiotic to treat and prevent UTI) 100 mg give one capsule by mouth in the morning for UTI prophylaxis (a treatment or action taken to prevent disease) for 30 continuous days. During an interview on 3/12/2026 at 1:34 p.m. with Pharmacy Consultant (PC), PC stated he is unsure why Resident 31 was ordered Macrodantin for 30 days. This type of order would normally be questioned.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement policies and procedures for influenza (Flu - an infection of the nose, throat and lungs) and pneumococcal (PNA - an infection that affects one or both lungs) vaccines (medications used to prevent diseases, usually given by injection or by mouth) for five of five sampled residents (Resident 2, 14, 31, 36, and 58). This failure had to the potential to affect the residents or resident representatives' (RP) right to make an informed decision regarding the Flu and PNA vaccines. Findings : During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted on [DATE] with diagnoses including but not limited to atherosclerotic heart disease (the hardening and narrowing of arteries due to plaque buildup), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hypertension (high blood pressure). During review of Resident 2's Flu and PNA vaccine consent form, dated 12/3/2025, the consent form indicated Resident 2 declined Flu and PNA vaccines. During a n interview on 03/11/2026 at 10:50 am with Director of Staff Development (DSD) and Infection Preventionist Nurse (IPN), IP stated Resident 2 has declined all vaccines and knows that Resident 2 declined Flu and PNA vaccines on the same day they declined COVID 19 vaccination 12/03/2025. IP stated Resident 2 declines vaccines and is not interested in getting any vaccinations. During a Review of Resident 14's admission Record, the admission Record indicated Resident 14 was admitted on [DATE] with diagnoses including but not limited to encephalopathy (brain dysfunction caused by infection, disease, or toxins), pneumonitis (swelling of the lung tissue), and dysphagia (difficulty swallowing). During a review of Resident 31's admission Record, the admission Record indicated Resident 31 was readmitted on [DATE] (original admission date 1/31/2017) with a diagnoses including but not limited to type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter waste). During a review of Resident 36's admission Record, the admission Record indicated Resident 36 was admitted on [DATE] with diagnoses including but not limited to dementia (decline in mental function), hyponatremia (low blood sodium levels) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 58's admission Record, the admission Record indicated Resident 58 was admitted on [DATE] (original admission date 2/21/2022) with diagnoses including but not limited to urinary tract infection (UTI - an infection in the bladder/urinary tract), dysphagia (difficulty swallowing), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During an interview on 3/11/2026 at 10:50 a.m. with DSD and IPN, DSD and IPN did not find current Flu and PNA vaccine consent forms for Resident 2, 14, 31, 36, and 58. DSD stated it is important to have consent forms so staff and residents can all be on the same page with resident care. During an interview on 03/12/2026 at 3:18 p.m. with DSD, DSD stated the importance of maintaining Flu and PNA P&P in accordance with national standards of practice. DSD stated it is important to have a P&P so the facility staff is all aware of what to do and how to handle situations according to standards of practice and to make sure that residents are receiving the care they need in accordance to regulations.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed provide education regarding risk and potential side effects of COVID 19 vaccine for five of five sampled residents (Resident 2, 14, 31, 36, and 58) and provide a declination form for all staff members declining COVID-19 vaccine boosters. These failures had the potential to affect the residents, residents' representatives, and staff's ability to make informed decisions regarding the COVID-19 vaccine.Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted on 12/ 02/2025 with diagnoses including but not limited to atherosclerotic heart disease (the hardening and narrowing of arteries due to plaque buildup), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and high blood pressure. During a review of Resident 2's COVID-19 booster vaccine (2025 - 2026 formula) consent form dated 12/03/2025, the COVID-19 consent form indicated Resident 2 did not give consent to receive the COVID-19 booster vaccine. During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was admitted on [DATE] with diagnoses including but not limited to encephalopathy (a brain dysfunction caused by infection, disease, or toxins), pneumonitis (swelling of the lung tissue), and dysphagia (difficulty swallowing). During a review of Resident 14's COVID-19 consent form dated 09/23/2025, the COVID-19 consent form indicated Resident 14 gave consent to receive the COVID-19 booster. During a review of Resident 31's admission Record, the admission Record indicated Resident 31 was readmitted on [DATE] (original admission date 1/31/2017) with a diagnoses including but not limited to type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter waste). During a review of Resident 31's COVID-19 consent form dated 9/11/2025, the COVID-19 consent form indicated Resident 31 gave consent to receive the COVID-19 booster. 1d. During a review of Resident 36's admission record, the admission Record indicated Resident 36 was admitted on [DATE] with diagnoses including but not limited to dementia (decline in mental function), hyponatremia (low blood sodium levels) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 36's COVID-19 consent form dated 9/09/2025, the COVID-19 consent form indicated Resident 36 gave consent to receive the COVID-19 booster. During a review of Resident 58's admission Record, the admission Record indicated Resident 58 was admitted on [DATE] (original admission date 2/21/2022) with diagnoses including but not limited to urinary tract infection (UTI - an infection in the bladder/urinary tract), dysphagia (difficulty swallowing), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 58's COVID-19 consent form dated 9/08/2025, the COVID-19 consent form indicated Resident 58 gave consent to receive the COVID-19 booster. During an interview on 3/11/2026 at 10:20 a.m. with Director of Staff Development (DSD), DSD stated vaccine consent forms are completed at the time of admission by Social Services Director (SSD), if residents have any questions regarding immunizations the nursing staff will follow up and speak to the resident or the family. DSD stated a COVID-19 information sheet is provided to the residents or Resident Representative (RP), but it does not specify the side effects (unwanted or unexpected symptoms) that can occur after administration of the COVID-19 vaccine. DSD stated it is important to provide education regarding vaccine side effects, to residents and RP, in case a resident experiences unwanted vaccine reactions; they know what steps to take. DSD stated the facility only provides printed vaccination education in English.During a review of facility's staff vaccination records, the vaccination records did not indicate the facility provided and maintained vaccination declination forms for employees that have declined vaccinations.During an interview on 3/12/2025 at 3:18pm with DSD, (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DSD stated the facility does not collect vaccine declination forms to their employees. DSD stated it is important to have declination forms in case employees are exposed to infection. DSD stated keeping staff educated on vaccinations/vaccine boosters can help protect residents and the facility from possible disease outbreaks.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement a Foley catheter dignity care plan for Resident 5 and ensure the Certified Nursing Assistant (CNA) 2 was seated at eye level during feeding one out of six sampled residents (Resident 16).This deficient practice has a potential for Resident's 5 and Resident's 16 dignity was not maintained.Findings:During a review of admission record Resident's 16 admission record (Face sheet) indicated Resident 16 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (impaired cognitive function, leading to dependence on others), depression (mood disorder characterized by sadness, hopelessness, helplessness), glaucoma (severe blurred vision), hearing loss, right shoulder osteoarthritis (pain and stiffness in joints), lack of coordination, dysphagia (difficulty swallowing).During a record review on 03/10/2026 of Minimum Data Set (MDS, Resident assessment tool) MDS (resident assessment tool) dated 01/06/2026, the MDS indicated Resident's 16 Brief Interview for Mental Status (BIMS) score was 1, meaning severe cognitive impairment. The MDS indicated Resident 16 required partial to substantial assistance with activities of daily living (eating, dressing, bathing, toileting, sitting, sitting, walking), maximum assistance and was dependent on transfers from bed to chair, toileting and showering.During a concurrent dining observation and interview on 03/10/2026 at 12:50 p.m. with CNA 2, CNA 2 was feeding Resident 16, pushing spoon with liquidized pureed (solid food blended with liquid and turned into puree) food into Resident16's mouth, standing in front towards the right side , facing Resident 16. CNA 2 stated that Resident 16 had a tray with pureed food which included a bowl of white mushroom soup, one pureed beef stew, a cup of orange color/vegetable soup, small cup of pureed kimchi, cup of milk, small bowl of apple sauce, and a cup of vanilla ice cream type pudding. CNA 2 alternated between offering soup and vanilla pudding. Resident 16 was observed clenching their jaw and keeping their lips tightly closed, with only occasional slight opening of the mouth-just enough for the tip of the spoon. With each spoonful offered, Resident 16 did not open their mouth wide, and much of the food dripped down onto the paper towel placed on the resident's chest. The tray ticket indicated the resident's diet as Puree (Liquified), Fortified, regular portion for lunch. During interview on 03/11/2026 03:13 p.m. with DSD stated the CNA 2 missed in-service for feeding Residents. No additional feeding assistance training provided to the nursing staff.During a record review of the facility's policy and procedures (P&P) dated 06/2025 titled Resident Dignity and Personal Privacy, the P & P indicated each resident's right to personal privacy includes the confidentiality of his or her personal and clinical affairs. Dignity means that when interacting with the residents, staff carries out activities that assist the resident in maintaining and enhancing his or her self-esteem and self-worth.

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F 0600 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect Resident 47's right to be free from physical abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) by Resident 78 when he hit Resident 47 on the face. This failure had the potential to result in Resident 47 being exposed to the risk of physical injury. Findings:During a record review of Resident 47's admission record indicated Residentˆ47 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures), dementia (a progressive state of decline in mental abilities), and depression (a mood disorder that causes persistent feeling of sadness and loss of interest). During a record review of Resident 47's Minimum Data set [MDS-a resident assessment tool), dated 2/2/26 indicated that Resident's cognitive was moderately impairment. The MDS indicated that Resident 47 required supervision or touching (helper provides verbal cues) assistance with eating. The MDS indicated that Resident 47 required substantial/maximal (helper does more than half the efforts) assistance with toileting, shower/bathe, lower body dressing and putting on/taking off footwear. During a record review of Resident 78's admission record indicated (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia, and history of falling. During a review of Resident 78's History and Physical (H&P) dated 11/14/2025, the H&P indicated that Resident 78 has fluctuating capacity (ability) to understand and make decisions. During a review of Resident 78's care plan report initiated on 10/31/2025 and titled, resident has behavior of screaming and cursing to others, throwing things and trying to hit. The care plan intervention indicated monitor for throwing things and trying to hit. Assist Resident 78 in developing more appropriate methods of coping and interacting. During a record review of Resident 47's interview report titled Content ofˆinterview dated 11/7/2025 indicated that Resident 47 was lying on the bed then suddenly Resident 78's hand hit my right side of the face. During record review of Resident 47's medical record titled Situation Background Assessment Recommendations (SBAR-a structured, four-step communication framework) Communication Form and Progress Note dated 11/07/2025 timed at 11:40 a.m., indicated that Resident 47 was lying in the bed and suddenly Resident 78 hand hit Resident 47's right side of the face. During a concurrent interview and record review on 3/11/2026 at 12:45 p.m. with the Director of Nursing (DON), Resident 47 and Resident 78's Incident Report titled Interdisciplinary Team (IDT-team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) Summary and Recommendations were reviewed. The DON stated that the incident was reported by Housekeeper (HK) 1 to Licensed Vocational Nurse (LVN) 4. The DON stated that LVN 4 interviewed both residents. And documented on Resident 47 IDT note that Resident 78 was sitting on the edge of the bed while Resident 47 was in his bed. HK 1 observed Resident 78 stood up and took steps forward and suddenly leaned and fell on top of Resident 47. Resident 78 showed aggressive behavior and started cursing at Resident 47. The DON stated that staff should have immediately separated the residents. The DON further stated the incident could have been prevented if HK 1 had called for assistance when Resident 78 attempted to get up, rather than observing without intervening. The DON defined abuse as any action in which one person does harm to another. During an interview on 3/12/2026 at 9:03 a.m. with HK 1, HK 1 stated that on 11/7/2025 in the morning (unknown time) HK 1 entered Resident 47's room to clean. At the time, Resident 78 stood up from the bed to use the restroom, lost balance, and hit Resident 47's right side of face with his hand. HK 1 stated that Resident 47 was lying in bed and Resident 78 was sitting at the edge of the bed prior to the incident. HK 1 reported that after standing, Resident 78 remained next to Resident 47 until a nurse (unknown name) entered the room. HK 1 stated that the incident was reported that same day to LVN (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. HK 1 further stated that when HK 1 returned later to continue cleaning, both residents still shared same room. During an interview and record review on 3/12/2026 at 12:30 p.m. with Director of Staff Development (DSD), Resident 47's interview report was reviewed. DSD stated that the day of the incident she was walking by Resident 47's room and HK 1 informed her that Resident 78 tried to get up and fell towards Resident 47's. DSD stated that Resident 47 interview report on 11/7/2025 indicated Resident 47 was lying on the bed then suddenly Resident 78's hand hit my right side of the face. DSD further stated that resident hitting another resident is considered abuse and it should be reported to the local law enforcement agency, ombudsman and to California Department of Public Health (CDPH). During a review of the facility's policy and procedures (P&P) titled, Abuse and Neglect Prohibition Policy dated 6/2024, indicated that the facility will provide the resident with a safe environment by identifying persons with whom he/she feels safe and conditions that would feel safe.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement it's written abuse polies and procedures (P&P), titled, Abuse and Neglect Prohibition Policy designed to prevent, respond to and report abuse- related incidents after physical abuse (includes, but is not limited to, hitting, slapping, punching, biting, and kicking) when staff did not immediately separate roommates Residents 47 and 78 who had physical altercation on 11/7/2026.This failure demonstrates the facility did not effectively implement its abuse prevention and response policy and procedures and did not ensure resident safety as required.Findings:During a record review of Resident 47's admission record , the admission record indicated Resident 47 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures), dementia (a progressive state of decline in mental abilities), and depression (a mood disorder that causes persistent feeling of sadness and loss of interest).During a record review of Resident 47's Minimum Data set [MDS-a resident assessment tool), dated 2/2/26 indicated that Resident's cognitive was moderately impairment. The MDS indicated that Resident 47 required supervision assistance with activities of daily living (ADL's- toileting hygiene, shower/bathing).During a record review of Resident 78's admission record indicated Resident 78 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia, and history of falling.During a review of Resident 78's History and Physical (H&P) dated 11/14/2025, the H&P indicated that Resident 78 has fluctuating capacity (ability) to understand and make decisions.During a review of Resident 47's interview report titled Content of interview dated 11/7/2025 indicated that Resident 47 was lying on the bed then suddenly Resident 78's hand hit my right side of the face.During an interview and record review on 3/11/2026 at 12:45 p.m. with Director of Nursing (DON), Resident 47 and Resident 78 nursing progress notes and care plan were reviewed. DON stated that there is no documentation in nursing progress notes indicating a room change. DON stated that nursing staff only documented in nursing progress notes on 11/7/2025 at 2:04 p.m. regarding the incident between Resident 47 and Resident 78. DON stated that nursing staff on each shift should have monitored Resident 47 for 72 hours after the incident.During an interview on 3/12/2026 at 9:03 a.m. with HK 1, HK 1 stated that on the morning of 11/7/2025 (exact time unknown), HK 1 entered Resident 47's room to clean. HK 1 reported that Resident 78 stood up from the bed to use the restroom, lost balance, and struck the right side of Resident 47's face with their hand. HK 1 stated that prior to the incident, Resident 47 was lying in bed and Resident 78 was sitting at the edge of the bed.HK 1 explained that after standing, Resident 78 remained next to Resident 47 until a nurse (name unknown) entered the room. HK 1 stated the incident was reported that same day to Licensed Vocational Nurse (LVN) 4. HK 1 further stated that when HK 1 later returned to continue cleaning, both residents were lying in bed and appeared calm. HK 1 confirmed that the residents were not separated immediately following the incident.During a review of the facility's policy and procedures (P&P) titled, Abuse and Neglect Prohibition Policy dated 6/2024, indicated that If you suspect abuse is a resident-to-resident incident, the resident who has in any way threatened or attacked another will be removed from the setting or situation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report allegations of abuse to the California Department of Public Health (CDPH) within the regulated time frame of two hours. a. by failing to report an allegation of physical abuse which occurred between Resident 47 and Resident 78 who are roommates on 11/07/2025. This deficient practice resulted in CDPH's inability to investigate the allegation of abuse timely and had the potential for other allegations of abuse to go unreported.Findings:During a record review of Resident 47's admission record indicated Resident^47 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures), dementia (a progressive state of decline in mental abilities), and depression (a mood disorder that causes persistent feeling of sadness and loss of interest). During a record review of Resident 47's Minimum Data set [MDS-a resident assessment tool), dated 2/2/26 indicated that Resident's cognitive was moderately impairment. The MDS indicated that Resident 47 required supervision assistance with activities of daily living (ADL's- toileting hygiene, shower/bathing). During a record review of Resident 78's admission record indicated Resident 78 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia, and history of falling. During a review of Resident 78's History and Physical (H&P) dated 11/14/2025, the H&P indicated that Resident 78 has fluctuating capacity (ability) to understand and make decisions. During a record review of Resident 47's Incident report interview portion titled Content of^interview dated 11/7/2025 indicated that Resident 47 was lying on the bed then suddenly Resident 78's hand hit my right side of the face. During an interview on 3/11/2026 at 12:45p.m. with the Director of Nurses (DON), the DON stated that the incident on 11/7/2026 was not reported for an unknown reason. The DON stated allegations of abuse, verbal, and physical are investigated and reported (to the Department). The DON stated that everyone in the facility is a mandated reporter and should follow the policy for abuse reporting. During an interview and record review on 3/12/2026 at 12:30 p.m. with Director of Staff Development (DSD), Resident 47's interview report was reviewed. DSD stated that the day of the incident 11/7/2025 she was walking by Resident 47's room and HK 1 informed her that Resident 78 tried to get up and fell towards Resident 47's. DSD stated that Resident 47 interview report dated11/7/2025 indicated Resident 47 was lying on bed suddenly Resident 78's hand hit Resident 47 right side of the face. DSD further stated that resident hitting another resident is considered abuse and it should be reported to the local law enforcement agency, ombudsman and to our agency. During an interview on 3/12/2026 at 11:18 a.m. with the Administrator (Admin), the administrator stated he was aware of the physical incident that occurred on 11/7/2025 between Resident 47 and Resident 78. The ADM stated that he was aware that allegations including physical abuse and must be reported to all appropriate agencies if needed as soon as possible During a review of the facility's policy and procedures (P&P) titled, Abuse and Neglect Prohibition Policy dated 6/2024, indicated that Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, neglect, or exploitation the Administrator or designee will perform the following: all alleged violation immediately but not later than twenty four hours-if the alleged violation does not involve abuse and does not result in serious bodily injury. Report the incident to the local Ombudsman or the local law enforcement agency by telephone as soon as possible.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement baseline care plan for physician orders for pain management and physical therapy (a healthcare specialty that helps individuals restore, maintain, and improve physical function, movement, and strength while reducing pain) for one of three sample residents (Resident 77).This failure had the potential to result in inadequate communication among staff regarding resident's 77 pain management needs and therapy interventions. Findings:During a record review of Resident 77's admission record it indicated Resident^77 was admitted to the facility on [DATE] with diagnoses of multiple fractures (broken bone) of pelvis (located at the lower part of the trunk), hyperlipidemia (abnormally high levels of fats in the blood), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 77's History and Physical (H&P), dated 3/3/2026, the H&P indicated, Resident 77 has the capacity (ability) to understand and make decisions. During a concurrent interview and observation on 3/9/3036 at 9:04 a.m. in Resident 77's room, Resident 77 was sitting in bed brushing her teeth while stating that she has been having pain in left leg and left heel. Resident 77 stated that she had received pain medication early in the morning, but the pain was not relieved. Resident 77 also stated that she would like to receive physical therapy to help legs get stronger. During a review of Resident 77's Order Summary Report (OSR), dated 3/12/2026, the OSR included the following orders: Ordered on 3/4/2026, Hydrocodone-Acetaminophen (is a combination medicine that is commonly taken for severe pain) Oral tablet 5-325 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) Give one tablet by mouth every 4 hours as needed for moderate pin (4-6) r/t pelvic fracture. Ordered on 3/4/2026, Hydrocodone-Acetaminophen Oral tablet 10-325 mg Give one tablet by mouth every 6 hours as needed for severe pain (7-100) r/t pelvic fracture. During a concurrent interview and record review on 3/11/2026 at 11:37 a.m. with Director of Rehabilitation (DOR), Resident 77's care plan (general) was reviewed. DOR stated that the facility evaluates all residents for Physical and occupational therapy upon admission. DOR stated that after completing the evaluation, the Physical Therapist (PT)/ Occupational Therapist (OT) should document Resident 77's goals and intervention in the care plan for all staff members to remain informed and consistent in the resident care. DOR further stated that staff had not initiated care plan addressing Resident 77 receiving physical therapy and pain management. The DOR stated that care plan should include Resident 77's pain medication orders. During an interview on 3/11/2026 at 1:15 p.m. with the Director of Nursing (DON), the DON stated that basic care plan included physician orders, dietary orders and therapy services. DON stated that basic care plans should be initiated within 48 hours of resident admission. DON stated that the care plan was important to initiate because it indicates the care the facility needs to provide for each resident. During a review of the facility's policy and procedures (P&P) titled, Baseline (Initial) Care Plan dated 6/2025, indicated^ the baseline care plans should address at a minimum, the following: initial goals based on admission orders, physician orders, physician orders, dietary orders, therapy services, social services and PASSR recommendations.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise resident care plans for two of four sampled residents (Resident 31 and 62). This failure had the potential to result in Resident 31 and 62 receiving inappropriate care due to conflicting information between care plan and medication orders. Findings: During a review of Resident 31's admission Record (Face sheet), the admission record indicated Resident 31 was admitted to the facility on [DATE] with diagnoses of dementia (a progressive state of decline in mental abilities) and major depressive disorder (a serious, common mental health disorder characterized by persistent sadness, low mood, and a loss of interest in activities). During a review of Resident 31's Minimum Data Set (MDS) dated [DATE], The MDSSection B indicated that Resident 31 uses glasses and hearing aides The MDS indicated that Resident 31 has moderate mental impairment. The MDS also indicated that besides the occasional feeling of loneliness, Resident 31 does not show or express other symptoms of depression. During a review of Resident 31's Physician Orders e Resident 31 had previous orders for Remeron,(a medication used to treat depression and stimulate appetite). no longer an active order on Resident 31's medication administration record (MAR). During a review of Resident 31's care plan, care plan indicated that Remeron use of Remeron is still listed as an active plan with interventions and outcomes related to active use of Remeron. During a review of Resident 62's admission Record (Face Sheet), record indicated Resident 62 was initially admitted to the facility on [DATE] with diagnoses including heart failure, chronic kidney disease, and atrial fibrillation (heart condition which affects the muscle's ability to pump blood through the heart effectively, causing high risk of blood clots). During a review of Resident 62's MDS dated [DATE],The MDS indicated that Resident 62 does not have mental function or memory issues. It also indicated that no walking devices are needed and Resident 62 only needs supervision or minimal assistance with daily activities. The MDS indicated that Resident 62 is taking an anticoagulant (Eliquis). During a review of Resident 62's care plan, Atrial Fibrillation care plan with review start date of 2/18/26 states, Administer Metoprolol succinate 12.5mg oral once daily and Eliquis 2.5mg twice daily starting as ordered on 1/23/2026. Physician Orders dated 01/22/2026, medication order states, resident is ordered Eliquis 2.5 mg by mouth in the afternoon for atrial fibrillation. Stop if notice any bleeding and seek medical attention. During a concurrent record review and interview with RN 1, at Nurse Station 1 on 03/12/2026 at 8:51 AM, RN 1 stated that MD 1 addressed the Pharmacy Consultant's (PharmC/PCˆ) recommendation and disagreed. RN 1 states that the original dose was 2.5 mg twice daily, but the MD 1 decreased dose to 2.5 mg Daily in afternoon. In the paper chart, RN found handwritten physician order from Cardiologist for 2.5mg twice daily, but verbal phone order from resident's MD 1, dated 1/22/26, states 2.5mg once daily in afternoon. During a review of the facility's policy and procedure titled, Comprehensive Care Plan, dated June 2025, the policy indicated that care plans should be re-evaluated and modified to reflect changes in care service and treatment. This should be done as necessary, quarterly, and with a significant change in status assessment.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to follow physician's order for pain management for one of three sampled resident (Resident 77). This failure had the potential to place Resident 77 at risk for adverse medication effects, including oversedation, respiratory depression and decline in overall health status. Findings:During a record review of Resident 77's admission record it indicated Residentˆ77 was admitted to the facility on [DATE] with diagnoses of multiple fractures (broken bone) of pelvis (located at the lower part of the trunk), hyperlipidemia (abnormally high levels of fats in the blood), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 77's History and Physical (H&P), dated 3/3/2026, the H&P indicated, Resident 77 has the capacity (ability) to understand and make decisions. During a review of Resident 77's Order Summary Report (OSR), dated 3/12/2026, the OSR included the following orders the order on 3/4/2026, Hydrocodone-Acetaminophen (is a combination medicine that is commonly taken for severe pain) Oral tablet 5-325 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) give one tablet by mouth every 4 hours as needed for moderate pain (pain level 4-6) r/t pelvic fracture. The order summary report order on 3/4/2026, Hydrocodone-Acetaminophen Oral tablet 10-325 mg Give one tablet by mouth every 6 hours as needed for severe pain (7-100) r/t pelvic fracture. During an observation on 3/11/2026 at 8:38 a.m. in Resident 77's room, Licensed Vocational Nurse (LVN) 2 entered the room with a medication cup and stated to Resident 77 I have your pain medication. Resident 77 took the medication cup from the LVN 2 took the pills. LVN 2 then walked out of the room. During a concurrent interview and record review of Resident 77's Medication Administration Record (MAR) on 3/11/2026 at 1:41 p.m. with LVN 2, LVN 2 stated that Resident 77 received Hydrocodone-Acetaminophen oral tablet 10-325 mg for right shoulder pain rated 7 out of 10 at 8:47 a.m. LVN 2 stated that they returned at 11:30 a.m. to reassess Resident 77's pain. LVN 2 stated that staff should reassessed Resident 77 pain within one hour after administering pain medication. LVN 2 stated that timely reassessment is important to evaluate the effectiveness of pain medication and ensure that the Resident 77 does not remain in pain. LVN 2 stated that Resident 77 pain was not reassessed within the required timeframe. During interview and record review on 3/12/2026 at 9:49a.m. with Registered Nurse (RN) 1, Resident 77's MAR dated March 2026 was reviewed. The MAR indicated that Resident 77 reported a pain level 5 out of 10 on 3/9/2026 at 2:34 a.m. and received Hydrocodone-Acetaminophen Oral tablet 10-325 mg instead of the ordered Hydrocodone-Acetaminophen Oral tablet 5-325 mg, which is prescribed for pain level of 4-6. RN 1 stated that Resident 77 received an incorrect dose and should have received the lower dose. RN 1 further stated that the nurse (unknown) who administered the pain medication did not follow the physician's order for pain. RN 1 stated that staff must match the resident's reported pain level with the corresponding medication order on the pain scale. As a result, Resident 77 received a higher dose of pain medication than ordered. During a review of the facility's policy and procedures (P&P) titled, Pain Management Program dated 6/2025, indicatedˆ monitor appropriately for effectiveness and/or adverse consequences .re-assess the resident's pain and consequences of pain. Ongoing pain assessment will be documented on the medication sheet.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe care of an arteriovenous (AV) fistula (abnormal connection of an artery and vein) for one of three sampled residents (Resident 28) receiving dialysis treatment (a procedure that cleanses the blood of waste and excess fluids when the kidneys have failed) by not using the correct arm to check blood pressure (B/P). This failure has the potential to result in injury for Resident 28 that can potentially damage the AV fistula. Findings: During a review of Resident 28's admission Record (Face Sheet) indicated Resident 28 was initially admitted to the facility on [DATE] with diagnoses including end-stage renal disease (irreversible kidney failure), type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), and dependence on dialysis. During a review of Resident 28's Minimum Data Set (MDS- a resident assessment tool), dated 1/25/26, MDS indicated that Resident 28 does not have cognitive (thought process, understanding, reasoning, or memory losses) problem. The MDS indicated that Resident 28 uses a walker and needs partial assistance with daily activities. The MDS also indicated that Resident 28 receives dialysis care. During a review of Physician's order dated 11/22/25, The order indicated Resident 28 has an AV fistula on the left middle arm with orders to monitor the fistula via an assessment every shift. Vital sign documentation for blood pressure (B/P, the force of blood pushing against the walls of arteries, measured by applying a cuff that causes high pressure) in the resident's chart indicates that blood pressure was taken on the left arm for the month of 3/2026: 3/12/26, 3/08/26, 3/07/26, 3/04/26, 3/03/26. During an observation on 3/10/26 at 2:45pm in Resident 28's room, no sign was present to indicate that blood pressure and blood draws are not to be taken on the Resident's 28 left arm due to an AV fistula. During a concurrent interview and record review on 03/11/2026 at 10:20 a.m. with Registered Nurse 1 (RN 1), the vital signs tab was reviewed. RN 1 stated that BP should be taken on the right arm if the resident has a fistula on the left arm. RN 1stated that the pressure from the cuff can damage the fistula and cause bleeding. ˆRN 1 stated that if the staff member is unfamiliar there is usually a sign above the head of the bed indicating that no BP or blood draw should be done on the affected side.ˆRN 1 stated that the nurses who documented that BP was performed on the left arm should have known better. During a review of the facility's policy and procedures (P&P) titled Hemodialysis, Care of Residents, dated 06/2025, the P&P indicated, do not take blood pressure on arm with dialysis shunt (another commonly used name for a fistula).

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facilityˆfailed toˆensure bed dimensions were inspected for appropriate size and weight for one of five sampled residents (Resident 47). This deficient practice has the potential to result in compromised resident safety associated with possible entrapment with bed rail use.ˆFindings:During a record review of Resident 47's admission record it indicated Residentˆ47 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures), dementia (a progressive state of decline in mental abilities), and depression (a mood disorder that causes persistent feeling of sadness and loss of interest). During a record review of Resident 47's Minimum Data set [MDS-a resident assessment tool), dated 2/2/26 indicated that Resident's cognitive was moderately impairment. The MDS indicated that Resident 47 required supervision assistance with eating . The MDS indicated that Resident 47 required substantial/maximal (helper does more than half the efforts) assistance with toileting, shower and lower body dressing. The MDS indicated that Resident 47 requires partial assistance to roll from lying on back to left and right side. During an observation on 3/09/2026 at 9:05 a.m. Resident 47 was observed lying in bed facing the doorway with two bedside rails (are adjustable metal or rigid plastic bars that attach to the bed) up, bed side rails were not padded, During a review of Resident 47's Order Summary Report (OSR), the OSR indicated an order dated 9/20/2025 indicated May have bilateral 1/3 side rails as enabler bed mobility/ activity of daily living (ADL's) care. During an interview and record review on 3/11/2026 at 10:15 a.m. with Registered Nurse (RN) 1, Resident 47's physician orders and Rail/Restraint/Device Assessment were reviewed. RN 1 stated that the bedside rails are assessed every quarter for Resident 47 and no one in the facility measures or inspects the bed rails. RN 1 stated that the last Rail/Restraint/Device Assessment for Resident 47 was completed on 2/2/2026 and did not indicate the measurements. During an interview and record review on 3/12/2026 at 7:40a.m. with the Maintenance Coordinator (MC), bedside rail log was reviewed. The MC stated that he does not measure the bed rails. The MC states that he only checks the bed monthly to ensure that the motor and brakes are working well. During an interview on 3/11/2026 at 1:15p.m. with the Director of Nursing (DON), the DON stated that bedside rails are not measured to ensure that bed dimensions are appropriate for the resident's size and weight. DON stated that the facility only completes rail/restraint/device assessment every quarter and monitors for episodes of entrapment every shift. The DON states that the facility has not had any incident with entrapment. During a review of the facility's policy and procedures (P&P) titled, Bed Rail Assessment and Management dated 6/2025, indicatedˆ?the facility is to assess resident prior to the implementation and use of bedside rails to ensure appropriate protocols have been followed such as ensure that the bed dimensions are appropriate for the resident's size and weight.

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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 observation, interview and record the facility failed to:Accurately account for Resident 62's home medications upon admission.Ensure the pharmaceutical waste container contained adequate liquid or chemical solution to render discarded tablets and capsules inaccessible and ensure the container's lid was secured according to manufacturer instructions.These deficient practices had potential to result in misappropriation or diversion of the medications.Findings:During record review of the admission Record, the record indicated Resident 62 was admitted to the facility on [DATE] with diagnoses of hypertensive heart failure (heart's muscle inability to pump blood efficiently due to long term untreated high blood pressure), abnormal gait and mobility (difficulty walking and maintaining balance), thrombocytopenia (disfunction in blood clotting causing bleeding, bruising) anemia (low red blood cells needed for oxygen transport to organs), chronic kidney disease (long term impairment in blood filtering ability and removal of wastes in urine), type 2 diabetes (long term disorder with unstable blood sugar levels ranging between high and low), atrial fibrillation (abnormal heart beat).During record review on 3/12/2026 of the Minimum Data Set (MDS - resident assessment tool), the MDS dated [DATE], indicated the Resident's 62 Brief Interview for Mental Status (BIMS) score was 13, meaning cognition was intact. The MDS indicated Functional Abilities of Resident 62 required helpers to set up, clean up with activities of daily living (eating, dressing, sitting, and toileting), and supervision on transfers from bed to chair, walking, and showering.During concurrent observation, interview, and record review on 03/10/2026 at 11:39 a.m. in the medication room with Registered Nurse (RN) 1, a bag containing Resident 62's home medications was observed. RN 1 stated she was unfamiliar with facility policy regarding home medications and did not know which or how many medications were in the bag. RN 1 stated the resident had been in the facility for almost two monthsDuring an interviews on 03/11/2026 at 11:15 a.m., RN 1 indicated that resident belongings should be documented by the social worker. During an interview on 03/11/2026 11:20 a.m. with Social Services Director (SSD), SSD stated when there is a new admission the process was to review the belongings list as completed by Certified Nurse Assistant (CNA) and entered the information into the electronic charting system SSD stated, When residents bring home medications, we don't keep it here, we ask family or friend to pick up and take home.2. During an observation on 03/10/2026 at 11:59 a.m., the pharmaceutical waste container was found to be full, with visible tablets and capsules not covered by any dissolving liquid or chemical agent. The lid was loose and not secured as tamperˆproof, allowing potential access to medications.During a subsequent interview on 3/10/2026 at 11:59 a.m. with RN1, RN 1 stated the Infection Preventionist (IP) was responsible for picking up the waste container, and stated that liquid should be added to dissolve wasted medications so they cannot be retrieved.During a review of an undated medication disposition log on 03/10/2026 at 12:15 p.m. showed the last entry dated 2/18/2026. The log lacked documentation identifying the residents' names associated with disposed medications.During a concurrent observation and interview on 03/10/2026 at 12:01 p.m., RN 2 opened the controlled medication compartment of the medication cart, showing two locked plastic kits for Schedule CII and CIV medications. RN 2 stated nurses account for these medications using the enclosed documentation slips. RN 2 also demonstrated a sharps container used to dispose of wasted controlled medications, emphasizing the importance of secure medication disposal.During review of belongings list for Resident 62 , the list showed no documentation indicating that home medications were brought in.During a concurrent interview and record review on 3/11/2026 at 1:24 p.m. with the Director of Nursing (DON), DON stated that upon discharge, leftover facilityˆissued medications could be sent home if ordered by the physician. The DON stated that staff are responsible for accounting for and documenting resident belongings, including any home medications, which should be reviewed for comparison and then returned to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family.During a concurrent interview and record review on 3/11/2026 at 2:05 p.m. of the Prescription Medication Disposition Record Pass Log dated 2/18/2026 with the DON, the DON stated this was an outdated form and that staff should have recorded the resident's name.During an interview on 03/12/2026 at 8:02 a.m., the DON stated the resident inventory list should be in the chart. The DON further stated that if home medications were brought in, staff must document the medication names and quantities, seal the items, label them with the patient's name, and store them securely until they can be sent home.During an interview and record review on 03/12/2026 at 8:29 a.m., the SSD stated they do not count medications and that only medications ordered by the attending physician may be administered. The SSD stated that Resident 62's belongings list include clothing and luggage, but no medications.During a phone interview on 03/12/2026 at 2:02 p.m., the Pharmacist Consultant (PC) stated home medications may be kept for shortˆterm use up to two months and must not include controlled substances. For longer storage, nurses or the DON should inventory the medications and arrange for disposal or return. The PC also stated the pharmaceutical waste container should not be full, should have a secure lid, and should contain liquid to dissolve medications.During a review of the facility's policy titled Residents' Personal Property, dated 06/2025, indicated that any personal items, including overˆtheˆcounter medications retained by the facility, must be inventoried upon admission, documented, and accounted for. The policy further required documentation of the release or disposal of resident belongings in the medical record.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to act upon a medication irregularity identified by the Pharmacy Consultant (PharmC/PC 2) for one of four sampled residents (Resident 62). This failure had the potential for Resident 62 receiving a repeated subtherapeutic dose (below the dosage amount needed for effective treatment) of eliquis (medication that thins blood, decreasing likelihood of blood clots in individuals who have higher risk factors for clots) and had the potential to cause harm by increasing risk of blood clots. Findings: During a review of Resident 62's admission Record (Face Sheet),the record indicated Resident 62 was initially admitted to the facility on [DATE] with diagnoses including heart failure (condition where the heart muscle isn't strong enough to pump enough blood to meet the body's needs) , chronic kidney disease (condition where the kidneys are damaged and can't properly filter out waste and fluid), and atrial fibrillation (heart condition which affects the muscle's ability to pump blood through the heart effectively, causing high risk of blood clots). During a review of Resident 62's Minimum Data Set (MDS- a resident assessment tool) dated 2/19/26, The MDS indicated that Resident 62 does not have cognitive (thought process, understanding, reasoning, or memory) losses. The MDS indicated that no walking devices are needed and Resident 62 needs very little help with daily activities. The MDS indicated that Resident 62 is taking an anticoagulant (Eliquis/ medication that thins blood, decreasing risk for blood clots). During a review of Resident 62's Physician Orders dated 01/22/2026, the physician's order indicated, eliquis 2.5 milligram (mg- unit of measurement) by mouth in the afternoon for atrial fibrillation. During a review of Consultant Pharmacist Recommendation to physician dated 2/27/26, the recommendation indicated Resident 62 is on Eliquis 2.5mg taking 1 tablet QD (daily) in the afternoon, however the recommended dosing is 2.5mg PO BID (twice daily). Please review and make changes as necessary to make sure the medication is therapeutic. During an observation on 03/12/2026 at 8:32 a.m. at Nurse Station 2 med cart, the current medication bubble pack for eliquis with the instructions for administration.During a concurrent record review and interview with Registered Nurse 1 (RN 1) on 03/12/2026 at 8:51 a.m., RN 1 stated that Medical Doctor 1 (MD 1) was aware of Pharmacy Consultant 2's (PharmC/PC 2) recommendation and disagreed. RN 1 states that the original dose was 2.5 mg twice daily, but MD 1 decreased the dose to 2.5 mg daily in afternoon. Resident 62's cardiologist (a doctor who specializes in the study or treatment of heart diseases and heart abnormalities) prescribed on 1/22/26 Eliquis 2.5mg twice daily. During a review of Resident 62's progress notes entered 2/2/26 11 days after the order was given, eliquis 2.5mg QPM PO (every evening by mouth) for atrial fibrillation. During a telephone interview on 3/12/26 at 1:38 p.m. with MD 1, he stated that he usually collaborates with the specialist, especially cardiologist and Pharmacist, to provide accurate therapeutic dose for the residents. MD stated he does not remember if someone relayed the Pharmacy recommendation to him.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor and document the signs and symptoms of depression for one out of one sampled resident (Resident 51) on Remeron (an anti-depressant medication).This failure had the potential to result in physical and psychosocial harm to Resident 51. Findings:During a review of Resident 51's admission record, the admission record indicated Resident 51 was admitted to the facility on [DATE] with diagnoses but not limited to major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and diabetes mellitus (a disorder characterized by difficulty in blood sugar control).During a review of Resident 51's Minimum Data Set (MDS - a comprehensive resident assessment tool), dated 1/16/2026, the MDS indicated an active diagnosis of depression.During a review of Resident 51's physician's orders, dated 7/24/2024, the orders indicated Remeron was started for major depressive disorder. The orders did not indicate to monitor for signs and symptoms of depression.During a review of Resident 51's care plan, dated 12/8/2025, the care plan indicated to observe resident for any signs and symptoms of depression.During a review of Resident 51's Medication Administration Record (MAR), dated 3/1/2026, the MAR did not indicate to monitor for signs and symptoms of depression.During an interview on 3/12/2026 at 2:05 p.m. with the Director of Staff Development (DSD), the DSD stated there is no documentation for behavioral monitoring for Resident 51. The DSD stated staff should have been monitoring and documenting signs and symptoms of depression.During an interview on 3/12/2026 at 12:51 p.m. with the Director of Nursing (DON), the DON stated Remeron long-term use is not acceptable.During a review of the facility's policy and procedure titled, Psychoactive Medication Management, dated July 2017, the P&P indicated residents on psychotropic medication (prescription drugs that treat mental health conditions by changing mood, thoughts, or behavior) will be monitored for behavior every shift and licensed nurses will document summary of behaviors and observations.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure a garbage dumpster lid was properly covered.This failure had the potential to attract pests and spread infection to facility residents.Findings:During an observation on 3/9/2026 at 7:45 a.m. in the parking garage, a garbage dumpster was filled with trash bags to the point that the lid could not fully close.During an interview on 3/10/2026 at 12:45 p.m. with the Dietary Supervisor (DS), the DS stated insects or animals could travel inside the garbage dumpster if the lid is left open and this could result in the residents becoming sick.During a record review of the facility's policy and procedure (P&P) titled, Waste Management, dated August 2017, the P&P indicated waste containers must be closable.During a review of Food Code 2022, dated 1/18/2022, the Food Code 2022 indicated garbage receptables must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of fourteen sampled residents (Resident 53) had call light within reach.This deficient practice had the potential to put Resident 53's at risk during emergency situations.Findings:During record review of the admission record, the admission record indicated Resident 53 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (impaired cognitive function, leading to dependence on others), embolism and thrombosis of deep veins of right lower extremity (blood clots in deep veins of a leg, obstructing normal blood flow to organs), anemia (low red blood cell count essential for oxygen transport), hypertension (chronic high blood pressure), osteoporosis (low density of bone tissue, prone to fractures), lack of coordination, dysphagia (difficulty swallowing), urinary retention (incomplete emptying of bladder during urination).During a review of the Minimum Data Set (MDS - resident assessment tool) indicated that MDS dated [DATE], indicated the Resident's 53 Brief Interview for Mental Status (BIMS) score was 6, meaning severe cognitive impairment. MDS indicated Functional Abilities of Resident 53 required partial to substantial assistance with activities of daily living (eating, dressing, bathing, sitting, and walking), maximum assistance and was dependent on transfers from bed to chair, toileting and showering.During a concurrent observation and interview on 3/9/2026 04:10 p.m. on Resident's 53's room, Resident 53's call light cable and button were on the floor under the nightstand, and not within reach of the resident.During an interview on 03/12/2026 12:08 p.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated their routine was to check rooms first thing in the morning, check the call light in the room, CNA 3 stated If the call light is on floor, put it back near residents' bed. CNA 3 stated before leaving the room it is important to check that everything is in place and call light on bed.During interview on 03/12/2026 12:33 p.m. with Licensed Vocation Nurse (LVN) 1 LVN 1 stated that call light was important for safety of residents to prevent falls, to meet needs in supplies, in diaper change, or bathroom. LVN 1 stated before leaving the room CNA and LVN should check for call light.During record review on 3/12/2026 care plan report, dated 10/27/2025 indicated place call light within reach.During a review of the facility's policy and procedure (P & P) dated 08/09 titled Call lights and use of the call cord system indicated Assure that the call light is within the residents reach when in their room or on the toilet. All residents will have a call light in place at all times. Keep constant watch on all call lights. Reposition call light within residents reach.

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	03/12/2026

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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 2 and Housekeeper (HK) 1 received abuse, neglect and exploitation training. This failure had the potential to place residents at risk for abuse, neglect, or exploitation due to lack identification and training.Findings:During a concurrent interview and record review on 3/11/2026 at 8:34 a.m. with Director of staff Development (DSD), the DSD stated that the facility had not provided staff with training on abuse, neglect and exploitation. The DSD stated that this training is important to ensure staff can recognize and protect residents. The DSD further stated that without this training, staff may fail to detect abuse, which could place residents at risk During an interview on 3/11/2026 at 1:41 p.m. with LVN 2, LVN 2 stated that the facility did not provide him with abuse or neglect training. LVN 2 stated that staff need proper training before working in the facility so they can provide safe care to the residents. LVN 2 further stated that staff assignments and workload at the facility were heavy. During an interview on 3/12/2026 at 9:03 a.m. with HK 1, the HK 1 stated that in the two years they had worked at the facility, they have received abuse training only at the time of hire. HK 1 stated that the facility had not provided staff with additional training on abuse or neglect. HK 1 also stated that they did not know which form to complete to report suspected abuse. During a review of the facility's policy and procedures (P&P) titled, Abuse and Neglect Prohibition Policy dated 6/2024, indicated that the facility abuse and neglect training program will be provided to all employees, through orientation and on-going sessions related to abuse prohibition practices at a minimum of annually, and will include review of: abuse and neglect policy, appropriate interventions to deal with aggressive and/or catastrophic reaction of residents, how staff should report their knowledge related to allegations without fear of reprisal.