STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555139	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miracle Mile Healthcare Center, LLC	1020 South Fairfax Ave Los Angeles, CA 90019

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to notify the physician when there is a significant change in resident's health condition for one of five sampled residents (Resident 1) by failing to: 1. Notify the attending physician and/or the Psychiatrist (PSYCH 1) when Resident 1 (R1) had increased paranoia (the unwarranted or delusional belief that one is being persecuted, harassed, or betrayed by others, occurring as part of a mental condition) episodes. Resident 1 stating, I was being poisoned, and refusing to take prescribed Risperdal (used to treat certain mental/mood disorders such as schizophrenia) and Keppra (used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain]). 2. Notify the attending physician when Resident 1 is refusing to take prescribed Risperdal (used to treat certain mental/mood disorders such as schizophrenia) and Keppra two or more consecutive times as indicated in the facility's P&P titled, Change in a Resident's Condition or Status. 3. Notify the physician regarding Resident 1 s last Keppra blood level when Resident 1 had an episode of seizure in 1/9/2024 according to facility's policy and procedure (P&P) titled, Seizure and Epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures) - Clinical Protocol. Resident 1 was transferred and hospitalized at general acute care hospital 1 (GACH1) for altered level of consciousness on 4/18/2024. While at GACH1, R1's blood was drawn for Keppra Level. On 4/20/2024, laboratory (lab) result of Keppra level in GACH1, was below the therapeutic level (result is less than two, normal is 6 to 46 micrograms per deciliter [mcg/m], a lab tests to look for the amount of a drug or medicine in the blood). This deficient practice resulted to resident 1's physician unaware of resident condition, delayed ordering the potential necessary interventions and placed the resident at risk for having seizures with associated complication and at risk for delayed preventative interventions. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/26/2024 at 8:27 p.m., while at the facility, an Immediate Jeopardy (IJ, a situation in which the facility's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of facility's Administrator (ADM), Director of Nursing (DON) and Assistant Director of Nursing/Registered Nurse 1 (ADON/RN 1) regarding the facility's failure to ensure a system is in place for staffs to notify physician for any change of condition and missed/refused medications and assess residents with increased signs and symptoms of paranoia and seizures. These deficient practices significantly increased increase the risk of early death from seizures include falls or other injuries that happen because of seizures. These injuries can be life-threatening. On 5/1/2024 at 2:54 p.m., the IJ was removed in the presence of the DON and ADON/RN 1 after the facility submitted an acceptable IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation) and the surveyor verified and confirmed through observation, interview, and record review onsite the facility's implementation of the IJ Removal Plan. The acceptable removal plan included the following actions: 1. As of 4/27/2024 Medical Director, who was also the R1's Medical Doctor (MD 1) was made aware by the nurses regarding R1's history of refusal of Risperdal and Keppra medication. As of 4/30/2024, R1 has been taking medications: Keppra and Risperdal. As of 4/30/2024, there are no refusals noted at this time for all 10 residents receiving Keppra and six residents receiving Risperdal. On 4/30/2024, the Director of Nursing Services informed the psychiatrist regarding the history of refusals of prescribed medication: Risperdal for R1. 2. On 4/26/2024, the Nurse Health Practitioner 1 (NP 1) was made aware of the R1'S blood Keppra Level and have ordered to have a repeat of blood Keppra Level on 5/1/2024. As of 4/26/2024, Keppra level was within normal range of 29.9 microgram - (ug - unit of measurement) /millimeter (ml - unit of measurement); normal range is 6 - 46 ug/ml and made aware MD 1. As of 4/26/2024, Keppra level was obtained from MD 1 by the ADON to all 10 residents on Keppra medications. As of 4/27/2024, the NP 1 seen R1 and was agreeable with the plan of care. 3. As of 4/27/2024, licensed nurse updated the Care Plan for history of refusal of medication of R1. As of 4/27/2024, licensed nurse has informed NP 1 history of R1's refusal of medications and documented in the clinical record of R1. On 4/30/2024, there are no refusal noted at this time for all 10 residents receiving Keppra. Licensed nurses will initiate change of condition (COC) if resident will have any refusal on medications and will notify the health practitioner. R1 has no episode of further refusal since 4/26/2024. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. As of 4/29/2024, Licensed Nurses were provided in-services by the facility nurse leaders with regards to and not limited to the following: initiating COC for refusal of medications, missed doses, notifying health practitioners of the refusal to medications, monitoring resident's episode of refusal to medications every shift, monitoring of episodes of behaviors such as paranoia and aggressive behaviors. 85 percent (% - unit of measurement) of licensed nurses was provided education by the DON/designee. The facility's nurse leader/designee will continue to provide in-services to all remaining nurses (15%) on their next work schedule. The Director of Staff Developer (DSD) followed up regarding implementation of the in-services and conducted skilled competency training to 85% of licensed nurses as of 4/30/2024 (remaining 15% of licensed nurses will be trained on skills competency upon upcoming shifts). 5. As of 4/27/2024, the Comprehensive and personalized care plan for R1 for fall management is developed and revised by the DON and coordinated to the staff for continuity of care. As of 4/29/2024, care plan for fall management is updated by the DON and collaborated with staff for continuity of care and implementation of the plan of care. 6. As of 4/27/2024, licensed nurse updated the R1 care plan for seizure management and seizure activity. Nurses will continue to document seizure monitoring in the MAR every shift as ordered. On 4/30/2024, all 10 residents on Keppra medication have orders for monitoring for seizure every shift by their primary physicians. The licensed nurses will inform the primary physicians regarding seizure activity and re-education provided by the DON regarding sign and symptoms of seizure. 7. Quality Assurance and Performance Improvement (QAPI- a program to improve the quality of life and care for services in nursing homes) meeting was conducted on 4/29/2024 with Medical Director, ADM, DON, Administrative personnel and ADON regarding concerns with IJ: Physician notification, informed consents, COC-episode of refusals, MAR missing documentations and manifested behaviors, seizure and fall management and precautions; the DON will continue to monitor twice a week for four weeks then once a month then quarterly and ensure the audits done in timely manner. Findings: A review of R1's Face sheet indicated the facility originally admitted the resident on 4/15/2022 and readmitted on [DATE] with diagnoses including epilepsy, unspecified, intractable (not easily managed or relieved), without status epilepticus (refers to a prolonged seizure that manifests primarily as altered mental status as opposed to the dramatic convulsions), schizophrenia, respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and dysphagia (difficulty swallowing food or liquid). A review of Resident 1's Fall Risk assessment dated [DATE] indicated R1's fall risk total score was 10 (10 or above represents high risk of falls). (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 1/19/2024, indicated R1 has intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and required moderate assistance to supervision from staff for activities of daily living (ADLs-toileting hygiene, personal hygiene, roll left and right, sit to stand repositioning, and toilet transfer). The same MDS also indicated that R1 uses manual wheelchair. A review of R1's Progress Notes dated 1/9/2024 at 11:26 p.m., R1 noted to be having a seizure. Timed and lasted three minutes, placed R1 on left side, surrounding area kept clear for safety . post seizure disoriented, unable to answer questions. A review of R1's Situation Background Assessment Recommendation (SBAR - a written or verbal communication tool used to provide essential and concise information, usually during crucial situations), dated 1/15/2024 indicated, R1 found in sitting position between his bed and roommates' bed with wheelchair at the end of his bed. A review of R1's SBAR dated 1/31/2024 indicated, R1 refused Keppra tablets (times refusals) . R1 stated angrily, you guys are trying to poison me, this medical makes me sleepy. A review of R1's MAR for January 2024 indicated four doses (a.m. and p.m.) of Keppra documented as N (refused), two doses were refused consecutively on 1/6/2024 for morning and afternoon dose, three doses (a. m. and p.m.) of Keppra documented as blank (no annotation), one dose of Risperdal is refused on 1/5/2024, one dose of Risperdal was documented as blank on 1/6/2024, 48 paranoia episodes was documented, and four shift had no documentation for monitoring episodes of seizures, two episodes of seizures was documented. A review of R1's Keppra blood level lab test collected on 2/21/2024, date resulted 2/21/2024, indicated Keppra level was 7.2. A review of R1's MAR for February 2024 indicated eight doses of Keppra documented as N (refused), two doses were refused consecutively on 2/1/2024 for morning and afternoon dose and on 2/5/2024 and 2/6/2024, three doses (a.m. and p.m.) of Keppra documented as blank (no annotation), six doses of Risperdal is refused on 2/16, 2/17, 2/18, 2/20, 2/21, and 2/22/2024, two doses of Risperdal was documented as blank on 1/6/2024, 23 paranoia episodes was documented, and seven shift had no documentation for monitoring episodes of seizures. A review of R1's SBAR dated 3/7/2024 indicated, at around 3:22 p.m., notified by Activity Staff 1 (AS1), R1 sitting in wheelchair at patio with other residents, AS1 suddenly heard a thud sound and turned his head towards residents and saw R1 on floor lying on right side and possibly hit his head on the floor . A review of R1 Progress Notes dated 3/7/2024 indicated, R1 was asked how the incident happened but not able to relay how the incident happened, and simply stated, my medicine taken this morning makes me dizzy and slip to the floor off wheelchair. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R1's MAR for March 2024 indicated five doses (a.m. and p.m.) of Keppra documented as N (refused), three doses were refused consecutively on 3/8, 3/9, and 3/11/2024 for morning dose and on 3/10/2024 documented as blank (no annotation), 10 doses of Risperdal is refused on 3/2,3/6, 3/8, 3/9,11,12, 13,16,25 and 3/312024, two doses of Risperdal was documented as blank on 3/10 and 3/17/024, 32 episodes of paranoia was documented and 22 shifts had no documentation for monitoring episodes of seizures. A review of R1's MDS dated [DATE], indicated R1 has severely impaired cognition for daily decision-making and required moderate assistance to supervision from staff for ADLs-toileting hygiene, personal hygiene, roll left and right, sit to stand repositioning, and toilet transfer. The same MDS also indicated that R1 uses manual wheelchair. A review of R1's SBAR dated 4/18/2024 indicated, on 4/17/2024 at 10:55 p.m., R1 was sitting near the nursing stations when Registered Nurse 2 (RN2) noticed R1 mental status is altered after assessment, he (R1) was not oriented to person, place and time . transferred on 4/18/2024 to GACH1 for further evaluation. A review of R1's GACH1 Emergency Department Notes indicated the following: i. R1 presented in the Emergency Department (ED) on 4/18/2024 with chief complaints of altered mental status. ii. R1 was shouting, having flights of ideas, not answering questions appropriately on triage (methods used to assess patients' severity of injury or illness within a short time after their arrival), stated his name was [NAME], and was staring into space. iii. R1 appeared severely confused, was speaking slowly & was giving verbal responses that had no relation to Psychiatrist evaluation, R1 started speaking in English so then encounter was done in English. R1 was alert and oriented times zero and appeared detached from his (R1) immediate environment. Patient (R1) is not responding to internal stimuli nor appear hypervigilant. iv. GACH1 with Keppra blood level undetectable until discharge back to the facility on [DATE]. A review of R1's Keppra blood level lab test collected at GACH1 on 4/18/2024, date resulted 4/20/2024, indicated Keppra level was less than two. A review of R1's Psychotropic Medication Care plan, initiated on 4/22/2024 indicated, R1 requires the use of psychoactive medications for schizophrenia with approaches/plan included, to supervise and give reassurance of well-being, evaluate behaviors/medication as necessary and report any COC to Physician. A review of R1's Behavioral Patterns Care plan, initiated on 4/22/2024 indicated, R1 have behavioral patterns related to schizophrenia with goals that R1 will not have more than 1 episodes of paranoia, with approaches/plan included to monitor R1's behavior frequently and record every shift, explain that his (R1) behavior is inappropriate and unacceptable and redirect behavior, evaluate effectiveness and adverse side effects (ASE) of medications for possible reduction of meds and notify Physician of any significant findings or changes immediately. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R1 Physician's Orders, dated 4/22/2024 indicated, i. Keppra 500 milligram (mg - unit of measurement) tablet, give two tablets by mouth twice daily for seizure disorder (9 a.m. and 5 p.m.) ii. Risperdal 1 mg tablet by mouth daily for schizophrenia manifested by paranoia and fear others are trying to poison him. (9 a.m.) iii. Monitor for seizure activity every shift (three times daily) iv. Monitor for diagnosis schizophrenia manifested by (m/b) paranoia and fear others are trying to poison him every shift and indicate total number of behaviors. A review of Resident 1's Fall Risk assessment dated [DATE] (readmission) indicated R1's fall risk total score was 17. During a concurrent interview and record review of R1's SBAR and Progress Notes (November 2023 through April 2024) with Assistant Director of Nursing/Registered Nurse 1 (ADON/RN1) on 4/24/2024 at 3:20 p.m., ADON/RN 1 reviewed R1's Progress Notes and stated, R1's SBAR and Progress Notes did not indicate if MD1 was notified on 1/9/2024 regarding R1's latest Keppra blood level according to their P&P. ADON/RN 1 further stated no documented that PSYCH 1 was notified regarding Resident 1 increasing episodes of paranoia. ADON/RN1 further indicated, R1's incident of falls could be an indication that R1 had seizure as these fall incidents were not observed and seizure have many different forms of s/sx. A review of R1's MAR for April 2024 indicated 10 paranoia episodes was documented. During a concurrent interview and record review of R1's MAR for the months of January to April 2024 with ADON/RN1 on 4/26/2024 at 6:40 p.m., ADON/RN1 stated, if MAR for Keppra and Risperdal is blank, if means it was not documented, and it did not happen and was not given. ADON/RN1 stated, the monitoring for paranoia episodes did not indicate if MD1 was notified for the multiple episodes of paranoia and what the interventions was implemented by the nurses. ADON/RN1 further stated, if MAR for seizure monitoring is blank in the MAR, it did not indicate if R1 had an episode of seizures, therefore, unable to indicate if medications were effective. During a concurrent observation and interview with R1 on 4/24/2024 at 10:52 a.m., R1 stated, he had epilepsy since he was [AGE] years old, and he does not like taking his medications because it makes him sleepy. During an interview with AS1 on 4/24/2024 at 3:20 p.m., AS1 stated, he heard a loud thump sound in the patio where R1 was and then found him lying on the floor. AS1 stated, he did not see how R1 fell on the floor. AS1 further stated, he thought he (R1) had a seizure as he was known to have multiple of seizure episodes in the past. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A concurrent observation and interview with R1 on 4/25/2024 at 9:06 a.m., R1 was observed lying on very right-side edge of the bed with eyes closed. R1 then opened his eyes and asked for a coffee. R1 stated, he had not taken his morning medications today because he doesn't like taking them. When asked if the medications were offered yet, R1 stated no, and growled, R1 further stated, he does not want to talk anymore. During an interview with Licensed Vocational Nurse 2 (LVN2) on 4/25/2024 at 10:18 a.m., LVN2 stated, she had not administered R1's medications because he was hallucinating this morning (4/25/2024). LVN2 stated, R1 growled when she came and saw him when they passed the breakfast tray. LVN2 stated, she did not offer his medications, and explained the risk and benefits of refusing medications. LVN2 stated, she would always assess R1's mood in the morning and would wait until he is calm to administer his medications. LVN2 stated, R1's medications are usually given after 10 a.m., or sometimes, medications are not given at all as he (R1) tends to refuse medications and treatment. LVN 2 further stated Resident 1 refuses his medication because he (R1) thinks was being poisoned. LVN2 further stated, she did not notify MD1 regarding medications not being administered on timed schedule. During an interview with MD1 on 4/26/2024 at 9:56 a.m., MD1 stated, he was not notified regarding R1's medication refusal and/or not administered on scheduled yesterday (4/25/2024). MD1 stated, if Keppra level is below therapeutic level, it may mean that residents were not receiving the medications as ordered which may cause residents to have seizures that causes falls and injury. MD1 further stated, nurses are to ensure residents take their medications as ordered, but if they refuse, they need to notify the physicians and update the plan of care. MD1 stated, staffs should also document in detail what the interventions are if they (residents) refuses care and treatment. MD1 stated, staffs should document in each MAR and MAR should not be left blank. MD1 stated, he was also the Medical Director in the facility, and he is unsure if all staffs are following the protocol. During an interview NP2 on 4/26/2024 at 5:55 p.m., NP2 stated, R1 was selective with medications and treatment. NP2 stated, she was not aware of the multiple episodes of R1's refusal of Risperdal and paranoia episodes when reviewed MAR for 1/2024, 2/2024, 3/2024 and 4/2024. NP2 stated, if she would've known, she could have increased the dose of Risperdal as R1's current medication treatment for his schizophrenia was ineffective. A review of facility's P&P titled, Seizures and Epilepsy - Clinical Protocol, reviewed on 1/25/2024, the P&P indicated, the nurse shall assess and document/report the following . whether resident has a known seizure disorder or history of actual seizure activity; date of most recent actual seizure activity; last blood level of any anticonvulsants being given . The staff will identify and report individuals who may be having a seizure; examples of s/sx include sudden onset of confusion, aura, visual or auditory hallucinations, difficulty speaking or understanding speech, severe dizziness, loss of consciousness, loss of balance or coordination, sudden numbness, tingling, or weakness of the face or in an arm or leg . the physician should help the staff distinguish seizure activity from other abnormal movements and reasons for change in mental status or level of consciousness . the physician will monitor antiepileptic medication blood levels periodically, where applicable, the physician should document why additional doses may not be needed to address low blood levels. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of facility's P&P titled, Requesting, Refusing and/or Discontinuing Care or Treatment, reviewed on 1/25/2024, the P&P indicated, residents have the right to request, refuse and/or discontinue treatment prescribed by his or her healthcare practitioner, as well as care routines outlined on the resident's assessment and plan of care . If a resident requests, discontinues or refuses care or treatment, the Unit Manager, Charge Nurse, or Director of Nursing Services will meet with resident to: determine why the resident is requesting, refusing or discontinuing care or treatment; try to address the residents' concerns and discuss alternative options; and discuss the potential outcomes or consequences of the resident's decision . Detailed information relating to the request, refusal or discontinuation of care or treatment will be documented in the resident's medical record . the healthcare practitioner must be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the request. A review of facility's P&P titled, Change in a Resident's Condition or Status, reviewed on 1/25/2024, the P&P indicated, facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status . The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): significant change in the resident's physical/emotional/mental condition . refusal of treatment of medications two or more consecutive times. According to the Epilepsy Foundation, Missed doses of seizure medications is the most common cause of breakthrough seizures. According to the Centers for Disease Control and Prevention (CDC - the nation's leading science-based, data-driven, service organization that protects the public's health), factors that increase the risk of early death from seizures include falls or other injuries that happen because of seizures. These injuries can be life-threatening.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to meet professional standards of quality of care to ensure documentation were completed after administration of medications to each resident for four of eight sampled residents (Resident 1, 3, 4, 5). This deficient practice had the potential to result in medication error, which could negatively impact residents' health and safety. Findings: A review of Resident 1 (R1)'s Admission Record indicated the facility originally admitted the resident on 4/15/2022 and readmitted on [DATE] with diagnoses including epilepsy, unspecified, intractable (not easily managed or relieved), without status epilepticus (refers to a prolonged seizure that manifests primarily as altered mental status as opposed to the dramatic convulsions), Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and dysphagia (difficulty swallowing food or liquid). A review of Resident 3 (R3)'s Admission Record indicated the facility admitted the resident on 2/16/2024 with diagnoses including chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure), type 2 diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]) and epilepsy. A review of Resident 4 (R4)'s Admission Record indicated the facility admitted the resident on 1/16/2024 with diagnoses including end stage renal disease (ESRD-a medical condition in which a person's kidney [organ in the body that lifters waste and excess fluid from the blood] function stop functioning on a permanent basis), DM, encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood). A review of Resident 5 (R5)'s Admission Record indicated the facility admitted the resident on 7/19/2023 with diagnoses including muscle wasting and atrophy (characterized by a significant shortening of the muscle fibers and a loss of overall muscle mass), DM and hyperlipidemia (abnormally high levels of fats in the blood). During a concurrent medication pass(administration) observation and interview with Licensed Vocational Nurse 2 (LVN2) on 4/25/2024 at 9:14 a.m., LVN administrated medications to Resident 1, 3, 4, and 5, however, LVN2 did not document in the Medication Administration Record (MAR) after each resident's medication pass. When asked when LVN 2 should document the medication administration in the MAR, LVN2 stated, she would document in the MAR after having administered medications to three-four residents, sometimes even more residents. LVN2 further stated that, it depends how busy she is, but she doesn't have time documenting after each resident. (continued on next page)

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Miracle Mile Healthcare Center, LLC	1020 South Fairfax Ave Los Angeles, CA 90019

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Assistant Director of Nursing/Registered Nurse 1 (ADON/RN1) on 4/26/2024 at 6:40 p.m., ADON/RN1 stated, documentation in MAR should be done right after each medication pass for each resident. ADON/RN1 stated, this (not documenting after each medication pass) puts residents at risk of medication error. A review of facility's policy and procedures (P&P) titled, Administering Medications, reviewed on 1/25/2024, indicated, the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 43454 Based on observation, interview, and record review, the facility failed to ensure: 1. One of three sampled residents (Resident 8 [R8]) received Risperdal (medication used to treat certain mental illnesses and or/mood disorders such as schizophrenia [a disorder that affects a person's ability to think, feel, and behave clearly]) as prescribed by the attending physician (MD1). 2. MD 1 was made aware R8 was refusing to take Risperdal as ordered and was exhibiting psychosis (a mental disorder characterized by a disconnection from reality) episodes manifested by (m/b) R8 refusing to treatments, sitting on the floor, and refusing to get back into bed while yelling and threatening staff when asked to into bed. These deficient practices had the potential to place R8 at risk for unnecessary psychotropic drugs (medications used to treat mental health disorders) side effect and adverse consequence such as a decline in quality of life and functional capacity. Findings: A review of R8's Facesheet indicated the facility originally admitted R8 on 3/1/2024 with diagnoses including acute psychosis (acute mental health condition when there is a loss of contact with reality) and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations). A review of R8's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool) dated 4/25/2024, indicated R8 had some difficulty in new situations. The MDS indicated R8 required moderate assistance from staff for activities of daily living (ADLs-toileting hygiene, upper and lower body dressing, roll left and right, sit to stand repositioning, and toilet transfer). The MDS also indicated R8 exhibited verbal behavioral symptoms including threatening and cursing others and screaming at others. A review of R8 Physician's Orders, dated 4/22/2024, indicated the following orders: i. Risperdal one (1) milligram (mg-unit of measure) tablet by mouth twice a day every day for acute psychosis m/b yelling at staff. ii. Monitor acute psychosis m/b yelling at staff every shift and non-compliance with medications every shift. A review of R8's Care plan (CP - a plan for an individual's specific health needs and desired health outcomes) titled, Change of Condition due to non-compliant with medications . Risperdal, dated 5/14/2024, the goal indicated R8 will be compliant with medications. The CP did not include intervention(s) for non-compliance with medications. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R8's Care plans initiated on 6/4/2024, indicated, R8 had behavioral patterns related to psychosis, indicated R8 will not have more than zero episodes of getting out of bed. The CP approaches/plan included to notify MD of any significant findings or changes. A review of R8's Progress Notes (Nurse's notes) dated 6/2/2024 indicated Licensed Vocational Nurse (LVN) 2, observed R 8 on the floor next to her bed. The Nurse's notes indicated R8 refused to get back to bed and chose to sit on the floor the with his belonging such as trash, food the entire shift. A review of R8's Nurse's Notes dated 6/4/2024, at 6:37 a.m., indicated R8 was observed sitting on the floor, refused to get back to bed, and remained on the floor. A review of R8's Nurse's Notes dated 6/4/2024, at 1:36 p.m., R8 was observed sitting on the floor next to her bed with trash and other personal belongings and refused to get back to bed. The Nurse's Notes indicated R8 yelled and screamed when staff attempted to convince her to get up from the floor. The Nurse's Notes indicated R8, threatened whoever attempted to help her. A review of R8's Nurse's Notes dated 6/5/2024, at 10:28 a.m., indicated R8 was sitting down on the floor and when staff asked R8 if she needed assistance to get back on the bed, R8 refused stating, This is where I want to be. A review of R8's Medication Administration Record (MAR) for 6/2024, indicated that on 6/1/2024 - 6/2/2024, 6/4/2024 - 6/16/2024, and 6/18/2024 - 6/20/2024:, i. N (Not administered) was documented for 13 doses of Risperdal as not administered at 9 a.m., on 6/2/2024, 6/4/2024 - 6/13/2024, 6/16/2024, 6/18/2024 at 9 a.m. ii. N was documented for 11 doses of Risperdal as not administered at 5 p.m., on 6/1/2024-6/2/2024, 6/4/2024, 6/7/2024 - 6/9/2024, 6/13/2024-6/15/2024, 6/19/2024 - 6/20/2024 at 5 p.m. iii. R8 had 84 episodes of psychosis manifested by (m/b) yelling at staff and non-compliance with medication. During a concurrent observation and interview with R8 on 6/19/2024 at 12:44 p.m., R8's room was observed with linen, blanket, big plastic bags with trashes and personal belongings on the floor. R8 appeared disheveled (of a person's hair, clothes, or appearance are untidy and disordered) and was talking incoherently (in a way that is difficult to understand and does not make sense). During an interview with Certified Nursing Assistant (CNA) 6 on 6/19/2024 at 12:50 p.m., CNA 6 stated, R8 tends to be non-compliant with care and does not like her room to be cleaned. CNA 6 stated, R8 would yell and scream at staff when she doesn't get her way. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the Assistant Director of Nursing (ADON) on 6/19/2024 at 1:07 p.m., R8's MAR for 6/2024 was reviewed. The ADON stated, on 6/1/2024 - 6/2/2024, 6/4/2024 - 6/16/2024, 6/18/2024 - 6/20/2024 the staff documented N for 13 doses of Risperdal for 9 a.m. dose, and N for 11 doses of Risperdal for the evening dose. The ADON stated, N means it was not administered. The ADON stated there was no documented evidence if R8 refused or any reason why Risperdal administered to R8. The ADON stated, there were no documentations on R8's progress notes to indicate if a MD was notified that R8 was not given Risperdal. The ADON stated, there were no progress notes as well that indicated physicians were notified of R8's psychosis episodes. The ADON further stated the staff were not following and implementing the facility's policy on Behavioral Assessment, Intervention, and Monitoring that indicated, The facility will provide, and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition, including onset, duration, intensity, and frequency of behavioral symptoms. A review of the facility's policy and procedures (P&P) titled, Behavioral Assessment, Intervention, and Monitoring, reviewed on 1/25/2024, indicated, The facility will provide, and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition, including onset, duration, intensity, and frequency of behavioral symptoms. A review of the facility's P&P titled, Requesting, Refusing, and/or Discontinuing Care or Treatment, reviewed on 1/25/2024, indicated, Residents have the right to request, refuse, and/or discontinue treatment prescribed by his or her healthcare practitioner, as well as care routines outlined on the resident's assessment and plan of care . If a resident requests, discontinues or refuses care or treatment, the Unit Manager, Charge Nurse, or Director of Nursing Services will meet with resident to determine why the resident is requesting, refusing, or discontinuing care or treatment; try to address the residents' concerns and discuss alternative options; and discuss the potential outcomes or consequences of the resident's decision.

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to: 1. Ensure one of five sampled residents (Resident 1[R1]) received Risperdal (medication used to treat certain mental and or/mood disorders such as schizophrenia [a disorder that affects a person's ability to think, feel, and behave clearly]) as prescribed by the attending physician (MD1). Resident 1's diagnoses included schizophrenia. 2. Ensure the MD1 were made aware that one of five sampled residents (R1) was refusing to take Risperdal as ordered and was exhibiting increased paranoia episodes manifested by (m/b) R1 stating, I was being poisoned, and hearing voices. 3. Ensure the Pharmacist (Pharm1) conducted a monthly medication regimen review (MRR - an important component of the overall management and monitoring of a resident's medication regimen) for one of five sampled residents' (R1) used of Risperdal. 4. Ensure a gradual dose reduction (GDR the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) was performed quarterly (three-month period for one of five sampled resident (R1) use of Risperdal. These deficient practices resulted in R1's having continued paranoia and leading to the R1's subsequent refusal of the medication Risperdal; leading to R1's to have unmanaged schizophrenia requiring R1 to be transferred to General Acute Care Hospital 1(GACH 1) due to altered level of consciousness on 4/17/2024. R1 did not receive the care and medications needed for the resident's condition placing R1 at increased risk for serious injury, serious harm, serious impairment and/or death. On 4/26/2024 at 8:27 p.m., while at the facility, an Immediate Jeopardy (IJ, a situation in which the facility's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of facility's Administrator (ADM), Director of Nursing (DON) and Assistant Director of Nursing (ADON) regarding the facility's failure to ensure the attending physician is notified when any resident refuses to take prescribed medications for resident's care and management. On 5/1/2024 at 2:54 p.m., the IJ was removed in the presence of the DON and ADON after the facility submitted an acceptable IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation) and the surveyor verified and confirmed through observation, interview, and record review, onsite the facility's implementation of the IJ Removal Plan. The acceptable removal plan included the following actions: 1. As of 4/26/2024, R1 received the Risperdal medication as ordered by the physician On 4/27/2024, the Medical Director who was also R1's primary physician was made aware by the nurses on R1's history of refusal of Risperdal medication. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. R1's informed consent for Risperdal, was updated by the Nurse Practitioner 2 (NP 2) on 4/27/2024 upon patient's re-evaluation. Informed consent is verified by the nurse during NP 2's visit on 4/27/2024. On 4/30/2024, licensed nurses provided education regarding Informed Consent by the DON. 3. On 4/30/2024, R1 has been taking R1's Risperdal medication. The health practitioner was made aware on 4/27/2024 by the nurses on R1's history of refusal of Risperdal medication. As of 4/28/2024, Resident 1's refusal of medication is being monitored by the licensed nurses every shift along with an order to inform the practitioner for any refusal and/ or missed doses. The medical records designee will conduct daily audits (Monday-Friday) and findings will be reported to the DON for immediate action. 4. As of 4/29/2024, Licensed nurses were provided in-services by the facility nurse leaders with regards to and not limited to the following: initiating change of condition (COC) for refusal of medications, missed doses, notifying health practitioners of the refusal to medications, monitoring resident's episode of refusal to medications every shift, monitoring of episodes of behaviors such as paranoia and aggressive behaviors. 85 percent (% - unit of measurement) of licensed nurses was provided education by the DON/designee. The facility's nurse leader/designee will continue to provide in-services to all remaining nurses (15%) on their next work schedule. The Director of Staff Developer (DSD) followed up regarding implementation of the in-services and conducted skilled competency training to 85% of licensed nurses as of 4/30/2024 (remaining 15% of licensed nurses will be trained on skills competency upon upcoming shift). 5. On 4/27/24, NP2 came to the facility and was made aware by the licensed nurse of R1's paranoia episodes. NP 2 re-evaluated the resident on 4/27/2024 and updated R1's behavior manifestations. On 4/27/2024, licensed nurses updated R1's manifestations monitoring in the Medication Administration Record (MAR- a report detailing the drugs or care administered to a resident by a healthcare professional). 6. As of 4/27/2024, R1'S MRR for Risperdal was done by the Pharm1 and evaluated by NP2. 7. As of 4/27/2024, R1's Risperdal medication was reviewed by the Interdisciplinary Team (IDT - a group of dedicated healthcare professionals who work to bring knowledge together to help residents receive the care they need) with NP 2. At this time, per NP 2 and IDT, GDR is not warranted and to continue the current dose for Risperdal. 8. Licensed nurses will initiate COC if a resident has any refusal episode and will notify the health practitioner. On 4/29/2024, the Director of Nursing Services informed MD1 regarding the following refusals of prescribed medications: Risperdal for R1. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	As of 4/29/2024, 85% of all licensed nurses were provided education by the DON/designee on continuously documenting refusals and notifying the MDs on any refusals in the residents' records. The facility's nurse leader/designee will continue to provide in-service to all remaining nurses (15%) who were not educated at this time during their next work schedule. The DSD will follow up on competency skills check and implementation of the in-services and training. On 4/30/2024, IDT spoke with R1 regarding his refusal, fall precaution, seizure precaution, and was educated about the risk of non-compliance, resident verbalized understanding. Next IDT meeting will be conducted on 5/7/2024. 9. Quality Assurance and Performance Improvement (QAPI- a program to improve the quality of life and care for services in nursing homes) was conducted on 4/29/2024 with Medical Director, ADM, DON, Administrative personnel, and ADON regarding concerns with IJ: MD notification, informed consents, Change of Condition-episode of refusals, MAR missing documentations and manifested behaviors, seizure and fall management and precautions. DON will continue to monitor twice a week for four weeks then once a month then quarterly and ensure the audits done in timely manner. Findings: 1. A review of R1's Facesheet indicated the facility originally admitted the resident on 4/15/2022 and readmitted R1 on 4/20/2024 with diagnoses including Schizophrenia. A review of R1's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool) dated 4/17/2024, indicated R1 has severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and required moderate assistance to supervision from staff for activities of daily living (ADLs-toileting hygiene, personal hygiene, roll left and right, sit to stand repositioning, and toilet transfer). A review of R1 Physician's Orders, dated 4/22/2024 indicated the following orders: i. Risperdal one (1) milligram (mg-unit of measure) tablet by mouth daily for Schizophrenia manifested by (m/b) paranoia (an extreme fear and distrust of others) and fear others are trying to poison him. ii. Monitor for diagnosis of Schizophrenia m/b paranoia and fear others are trying to poison him every shift and indicate total number of behaviors. A review of R1's Care plan (CP-a plan for an individual's specific health needs and desired health outcomes) indicated the following: i. a CP for psychotropic medication (medications that that affects behavior, mood, thoughts, or perception) initiated on 4/22/2024 indicated, R1 requires the use of psychoactive medications for Schizophrenia with approaches/to evaluate behaviors/medication as necessary and report any change of condition to Physician. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ii. a CP for behavioral patterns, initiated on 4/22/2024 indicated, R1 has behavioral patterns related to Schizophrenia with goals that R1 will not have more than 1 episodes of paranoia, with approaches and or plan that includes to monitor R1's behavior frequently and record every shift, explain that his (R1) behavior is inappropriate and unacceptable and redirect behavior, evaluate effectiveness and adverse side effects (ASE) of medications for possible reduction of meds and notify Physician of any significant findings or changes immediately. A review of R1's SBAR dated 4/18/2024 indicated that on 4/17/2024 at 10:55 p.m., Registered Nurse 2 (RN2) noticed R1 to be altered after assessment, he (R1) was not oriented to person, place and time. The SBAR further indicated that R1 was transferred to GACH1 for further evaluation. A review of R1's GACH1 Emergency Department Notes indicated the following: i. R1 presented in the Emergency Department (ED- a part of a hospital for treating people who have just come to the GACH, need to be treated quickly even without an appointment) on 4/18/2024 with chief complaints of altered mental status. ii. R1 was shouting, having flights of ideas (occurs when someone talks quickly and erratically, jumping rapidly between ideas and thoughts), not answering questions appropriately on triage (methods used to assess patients' severity of injury or illness within a short time after their arrival), stated his name was [NAME], and was staring into space. R1 appeared severely confused, was speaking slowly and was giving verbal responses that had no relation to Psychiatrist evaluation, R1 started speaking in English so then encounter was done in English. R1 was alert and oriented times (x) zero and appeared detached from his (R1) immediate environment. Resident (R1) is not responding to internal stimuli (changes, experiences, or feelings that occur within someone such as hunger or thirst) nor appear hypervigilant (a chronic state of heightened alertness and awareness). During a concurrent observation and interview with R1 on 4/24/2024 at 10:52 a.m., R1 stated, he does not like taking his medications because it makes him sleepy. During a follow-up interview with R1 on 4/25/2024 at 9:06 a.m., R1 stated, he (R1) had not taken his (R1) morning medications today because he (R1) does not like taking them. When asked if the medications were offered, R1 stated no, and growled. R1 further stated, he (R1) does not want to talk anymore. During an interview with Licensed Vocational Nurse 2 (LVN 2) on 4/25/2024 at 10:18 a.m., LVN 2 stated that LVN 2 had not yet administered R1's morning medications because R1 was hallucinating. LVN 2 stated, R1 growled when LVN 2 came and saw the resident. LVN 2 stated that LVN 2 did not offer R1's medication nor did LVN 2 explained the risk and benefits of refusing medication. LVN 2 stated that LVN 2 would assess R1's mood in the morning and would wait until R1 is calm to administer R1's due medications. LVN 2 stated that R1's medications are usually given after 10:00 a.m.; or sometimes, medications are not given at all as R1 tends to refuse medications. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's P&P titled, Administering Medications, reviewed on 1/25/2024, the P&P indicated, medications are administered within one hour of their prescribed time, unless otherwise specified . if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle MAR space provided for the drug and dose. A review of the facility's P&P titled, Change in a Resident's Condition or Status, reviewed on 1/25/2024, the P&P indicated, our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status . The nurse will notify the resident's Attending Physician or physician on call when there has been a: refusal of treatment or medications two or more consecutive times. 2. A review of R1's MAR for January 2024 indicated one dose of Risperdal is refused on 1/5/2024, one dose of Risperdal was documented as blank on 1/6/2024, and 48 paranoia episodes were documented. A review of R1's MAR for February 2024 indicated six doses of Risperdal is refused on 2/16, 2/17, 2/18, 2/20, 2/21, and 2/22/2024, two doses of Risperdal was documented as blank on 1/6/2024, and 23 paranoia episodes were documented. A review of R1's MAR for March 2024 indicated 10 doses of Risperdal is refused on 3/2,3/6, 3/8, 3/9,11,12, 13,16,25 and 3/312024, two doses of Risperdal was documented as blank on 3/10 and 3/17/024, and 32 episodes of paranoia were documented. A review of R1's MAR for April 2024 indicated 10 paranoia episodes was documented. A review of R1's Situation Background Assessment Recommendation (SBAR - a written or verbal communication tool used to provide essential and concise information, usually during crucial situations) indicated the following: i. R1's SBAR dated 1/31/2024 indicated, R1 refused Risperdal tablets (three times refusals) . R1 stated angrily, you guys are trying to poison me, this medication makes me sleepy. During a concurrent interview and record review with ADON on 4/26/2024 at 6:40 p.m., reviewed R1's MAR for 1/2024, 2/2024, 3/2024, and 4/2024. ADON stated that there were: i. One dose of Risperdal is refused on 1/5/2024, one dose of Risperdal was documented as blank on 1/6/2024 for 1/2024 MAR. ii. Six doses of Risperdal are refused on 2/16, 2/17, 2/18, 2/20, 2/21, and 2/22/2024, two doses of Risperdal were documented as blank on 1/6/2024, for 22/2024 MAR. iii. 10 doses of Risperdal are refused on 3/2,3/6, 3/8, 3/9,11,12,13,16,25 and 3/312024, two doses of Risperdal were documented as blank on 3/10 and 3/17/024 for 3/2024 MAR. ADON stated that the blank spaces in R1's MAR for Risperdal means that the medication was not given as it was not documented. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review with ADON on 4/26/2024 at 6:40 p.m., reviewed R1's MAR for 1/2024, 2/2024, 3/2024, and 4/2024. ADON stated that there were: i. 48 paranoia episodes documented that R1 had episodes of paranoia for 1/2024 ii. 23 paranoia episodes documented that R1 had episodes of paranoia for 2/2024 iii. 32 episodes of paranoia documented that R1 had episodes of paranoia for 3/2024 iv. 10 paranoia episodes documented that R1 had episodes of paranoia for 4/2024 ADON stated after reviewing R1's MAR from 1/2024 to 4/2024 that there was no indication that MD 1 was notified of the multiple episodes of paranoia. During an interview Nurse Practitioner 2 (NP 2) on 4/26/2024 at 5:55 p.m., NP2 stated that R 1 was selective with medications and treatment. NP 2 stated that NP 2 was not aware of the multiple episodes of R1's refusal of Risperdal and paranoia episodes noted in R1's MAR for 1/2024, 2/2024, 3/2024 and 4/2024. NP 2 stated that had NP2 known of R1's refusal and episodes of paranoia, NP 2 would have increased the dose of R1's Risperdal as R1's current medication treatment for his schizophrenia was ineffective. A review of the facility's P&P titled, Antipsychotic Medication Use, reviewed on 1/25/2024, the P&P indicated, Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review . The staff will observe, document, and report to the Attending Physician information regarding the effectiveness of any interventions, including antipsychotic medications. A review of the facility's P&P titled, Requesting, Refusing and/or Discontinuing Care or Treatment, reviewed on 1/25/2024, the P&P indicated, residents have the right to request, refuse and/or discontinue treatment prescribed by his or her healthcare practitioner, as well as care routines outlined on the resident's assessment and plan of care . If a resident requests, discontinues or refuses care or treatment, the Unit Manager, Charge Nurse, or Director of Nursing Services will meet with resident to: determine why the resident is requesting, refusing or discontinuing care or treatment; try to address the residents' concerns and discuss alternative options; and discuss the potential outcomes or consequences of the resident's decision . Detailed information relating to the request, refusal or discontinuation of care or treatment will be documented in the resident's medical record . the healthcare practitioner must be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the request. A review of the facility's P&P titled, Charting and Documentation, reviewed on 1/25/2024, the P&P indicated, the following information is to be documented in the resident medical record: objective observations; . changes in the resident's condition . Documentation in the medical record will be objective, complete, and accurate . Documentation of procedures and treatment will include care-specific details, including: whether the resident refused the procedure/treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555139	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miracle Mile Healthcare Center, LLC	1020 South Fairfax Ave Los Angeles, CA 90019

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. A review of R1's monthly medication regimen review (MRR - an important component of the overall management and monitoring of a resident's medication regimen) for Risperdal for the months of 1/2024, 2/2024 and 3/2024 indicated that the pharmacist consultant had no recommendations for R1. A review of R1's MAR for January 2024 indicated one dose of Risperdal is refused on 1/5/2024, one dose of Risperdal was documented as blank on 1/6/2024, and 48 paranoia episodes were documented. A review of R1's MAR for February 2024 indicated six doses of Risperdal is refused on 2/16, 2/17, 2/18, 2/20, 2/21, and 2/22/2024, two doses of Risperdal was documented as blank on 1/6/2024, and 23 paranoia episodes were documented. A review of R1's MAR for March 2024 indicated 10 doses of Risperdal is refused on 3/2,3/6, 3/8, 3/9,11,12, 13,16,25 and 3/312024, two doses of Risperdal was documented as blank on 3/10 and 3/17/024, and 32 episodes of paranoia were documented. A review of R1's MAR for April 2024 indicated 10 paranoia episodes was documented. During an interview with Pharm1 on 4/26/2024 at 9:03 a.m., Pharm1 stated that R1's MRR for Risperdal was reviewed and evaluated for the months of 1/2024, 2/2024 and 3/2024. Pharm1 stated that there were no recommendations required for R1 as R1 was compliant with the medication Risperdal. When asked if Pharm 1 was aware of R1's refusal of medications from 1/2024 to 4/2024; and paranoia episodes 1/2024 to 4/2024, Pharm1 did not answer. A review of the facility's P&P titled, Medication Regimen Review reviewed on 1/25/2024, the P&P indicated, the Consultant Pharmacist reviews the medication regimen of each resident at least monthly . The MRR involves thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example: medication regimes that appear inconsistent with the resident's stated preferences, duplicative therapies or omissions of ordered medications . an acute change of condition may prompt a request for a MRR, the staff member who identifies the change of condition follows reporting procedures to notify the physician. The physician may request a MRR be conducted within a specific timeframe. 4. During an interview with Pharm1 on 4/26/2024 at 9:03 a.m., Pharm1 stated that R1's last GDR for Risperdal was done on 9/2023. Pharm1 stated that R1's GDR evaluation for R1's Risperdal should be conducted quarterly (three-month periods). When asked how come R1's last GDR was done seven (7) months ago on 9/2023, Pharm 1 did not answer. A review of the facility's P&P titled, Antipsychotic Medication Use, reviewed on 1/25/2024, the P&P indicated, Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review . The staff will observe, document, and report to the Attending Physician information regarding the effectiveness of any interventions, including antipsychotic medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43454 Based on observation, interview, and record review, the facility failed to observe infection control measures to ensure the indwelling catheter (or known as Foley catheter, a tube that allows urine to drain from the bladder into a bag that is usually attached to the thigh) drainage bag was not touching the floor for one of one sampled resident (Resident 8). This deficient practice had the potential for cross contamination and placed the residents at risk for infection. Findings: A review of Resident 8's Admission Record indicated the facility originally admitted the resident on 4/6/2024 with diagnoses including congestive heart failure (CHF- a progressive condition that affects the pumping power of the heart muscle), type 2 diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), muscle wasting and atrophy (characterized by a significant shortening of the muscle fibers and a loss of overall muscle mass) and benign prostatic hyperplasia (BPH - a noncancerous enlargement of the prostate gland, is the most common benign tumor found in men). A review of Resident 8's Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 4/12/2024, indicated Resident 8 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making. Resident 8 required moderate assistance to supervision from staff for activities of daily living (ADLs-toileting hygiene, personal hygiene, roll left and right, sit to stand repositioning, and toilet transfer). The same MDS also indicated, Resident 8 uses manual wheelchair. A review of Resident 8's Care Plan (CP) for Foley catheter use, dated 4/6/2024, indicated, Resident 8 is at high risk for developing urinary tract infection (UTI- an infection in any part of the urinary system, including the kidney, bladder or urethra) and urinary trauma related to the use of foley catheter, with a goal of that Resident 8 will be free from signs and symptoms (s/sx) of UTI. During an observation of Resident 8 on 4/24/2024 at 11:53 a.m., Resident 8 was observed in the hallway wheeling himself in his wheelchair heading to the Activity Room, with his foley catheter bag dragging on the floor. Resident 8 passed by the nursing station where Licensed Vocational Nurse 4 (LVN4), Certified Nursing Assistant 1 (CNA1) and Assistant Director of Nursing / Registered Nurse 1 (ADON/RN1) were stationed. None of the staff acted to intervene Resident 8 while his foley catheter bag was being dragged on the floor. During a concurrent observation of Resident 8 and interview with ADON/RN1 on 4/24/2024 at 11:59 a.m. ADON/RN1 noticed Resident 8's foley catheter bag and stopped Resident 8 to fix his foley catheter bag. ADON/RN1 stated, it (the catheter bag) should not be dragging on the floor and should be hanging to the side of the wheelchair, off the floor. ADON/RN1 stated, this (with catheter bag dragging on floor) could put the resident at risk of contamination and spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures (P&P) titled, Catheter Care, Urinary, reviewed on 1/25/2024, indicated, the purpose of this procedure is to prevent catheter-associated urinary tract infections . Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag . be sure the catheter tubing and drainage bag are kept off the floor.