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	05/17/2024

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 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** 45524 Based on interview and record review, the facility failed to provide care, services, and advocacy for eight of 21 sampled residents (Residents 1, 2, 3, 4, 5, 6, 7, and 8) as per professional standards of practice, when the resident had a change in condition (COC, a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains) by failing to: 1. Failing to check blood sugar levels (FS) before meals and/ checking dinner and bedtime within minutes of each other. 2. Failing to administer insulin (a naturally occurring hormone your pancreas makes that's essential for allowing your body to use sugar (glucose) for energy. If your pancreas doesn't make enough insulin or your body doesn't use insulin properly, it leads to high blood sugar levels (hyperglycemia). A synthetic insulin [insulin is any pharmaceutical preparation of the protein hormone insulin that is used to treat high blood glucose for people whose insulin does not function appropriately]) with meals 5/3/2024 and 5/8/2024. 3. Failing to notify the physician about late blood sugar check and late insulin administration on 5/3/2024 and 5/8/2024. This failure had the potential to place Residents 1-8 at risk for unmanaged blood glucose that may lead to complications such as diabetic ketoacidosis, diabetic coma, blindness, organ failure, nerve damage and even death. Findings: A review of Resident 1 's admission record indicated the resident was admitted on [DATE] with diagnoses including, diabetes type 2 (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one ' s daily activities), and cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue). A review of Resident 1 's care plan titled DIABETES MELLITUS, dated 1/9/24 indicated, Resident 1 was at risk for hyperglycemia or hypoglycemia related to (r/t) diabetes mellitus (DM) with a goal of keeping Blood Sugar (BS) between 65-115mg/dl. The plan approaches included giving insulin as ordered and monitoring BS per Medical Doctor (MD) order. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 1 's Minimum Data Set (MDS- standardized data collection tool used to assess cognitive and functional status, and care needs) dated 4/15/24, indicated Resident 1 had some severe cognitive impairment (a decline in cognitive abilities such as language, memory reasoning, judgment, or perception that is not due to normal aging) and required substantial to maximum assistance for activities of daily living and required between setup or clean up assistance to supervision or touching assistance (ADL ' s: activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). A review of the Medication administration Record (MAR - includes key information about the individual's medication including, the medication name, dose taken, special instructions and date and time) for the month of May between 5/6/24 and 5/9/24 indicated, Resident 1 got BS levels checked at the following times: - 5/6/24 - BS scheduled at 4:30 pm and was checked at 9:58 pm. Level 145mg/dl - 5/7/24 - BS scheduled at 4:30 pm and was checked at 8:50 pm. Level 136mg/dl - 5/7/24 - BS scheduled at 9 pm and was checked at 8:51 pm. Level 136mg/dl - 5/8/24 - BS scheduled at 4:30 pm and was checked at 10 pm. Level 147mg/dl - 5/8/24 - BS scheduled at 9 pm and was checked at 10:09 pm. Level 167mg/dl. A review of Resident 2 's admission record indicated the resident was admitted on [DATE] with diagnoses including, diabetes type 2 (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure), and major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy). A review of Resident 2 's care plan titled DIABETES MELLITUS, dated 3/2/23 indicated, Resident 2 had the potential for hyperglycemia or hypoglycemia secondary to diagnosis of DM with a goal of keeping BS within normal level of 70-120mg/dl. The interventions included monitoring labs and BS as ordered. A review of Resident 2 's MDS dated [DATE], indicated Resident 2 had some moderate cognitive impairment (when you have a slight decline in your mental abilities, like memory and completing complex tasks) and required substantial to maximum assistance for activities of daily living and required between setup or clean up assistance to supervision or touching assistance for ADLs. A review of the MAR audit between 5/9/24 to 5/14/24 indicated the following: - 5/10/24-BS scheduled at 4:30 pm and was checked at 7:24 pm. Level 190mg/dl. 2 units of Humulin R (a short-acting insulin, which means it can cover insulin needs for meals eaten within 30 minutes) were administered per sliding scale (varies the dose of insulin based on blood glucose level). - 5/10/24 - BS scheduled at 9 pm and was checked at 8:58 pm. Level 212mg/dl. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4 units of insulin were administered. A review of Resident 3 's admission record indicated the resident was admitted on [DATE] with diagnoses including, diabetes type 2 (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure), and 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 3 's care plan titled DIABETES MELLITUS, dated 5/1/24 indicated, Resident 3 had was at risk for hyperglycemia or hypoglycemia r/t DM with a goal indicating BS will be 65-115 mg/dl. The interventions included giving insulin and monitoring BS as ordered. A review of Resident 3 's MDS dated [DATE], indicated Resident 3 required substantial to maximum assistance for activities of daily living and required substantial/maximum assistance for ADLs. A review of the MAR audit between 5/1/24 to 5/14/24 indicated the following: - 5/2/24-BS scheduled at 11:30 am and was checked at 2 pm. Level 310mg/dl. 10 units of insulin lispro (a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) were administered per sliding scale. - 5/7/24 - BS scheduled at 4:30 pm and was checked at 7:34 pm. Level 388mg/dl. 12 units of insulin were administered. - 5/7/24 - BS scheduled at 9 pm and was checked at 10:52 pm. Level 303mg/dl. 10 units of insulin were administered. -5/13/24 - BS scheduled at 4:30 pm and was checked at 6:08 pm. Level 378mg/dl. 12 units of insulin were administered. A review of Resident 4 ' s admission record indicated the resident was admitted on [DATE] with diagnoses including, diabetes type 2 (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue), and hyperlipidemia (high levels of fats (lipids) in the blood which can increase the risk of heart attack and stroke because blood can't flow through the arteries easily). A review of Resident 4 ' s care plan titled DIABETES MELLITUS, dated 11/18/23 indicated, Resident 4 had was at risk for hyperglycemia or hypoglycemia r/t DM with a goal of keeping BS less than 200 mg/dl. The interventions included giving insulin and monitoring BS as ordered. A review of Resident 4 ' s MDS dated [DATE], indicated Resident 4 was cognitively intact (has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment) required between supervision or touching assistance to partial/moderate assistance for all ADLs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the MAR audit between 5/7/24 to 5/14/24 indicated the following: - 5/7/24-BS scheduled at 9 am and was checked at 11:02 am. Level 141mg/dl. - 5/7/24 - BS scheduled at 5 pm, checked at 7:46 pm. Level 141mg/dl 2 units of Novolin R administered. - 5/7/24 - BS scheduled at 4:30 pm and was checked at 7:46 pm. Level 141mg/dl. 2 units of insulin were administered. - 5/7/24 - BS scheduled at 10 pm and was checked at 7:47 pm. Level 144mg/dl. 2 units of insulin were administered. -5/8/24 - BS scheduled at 9 pm and was checked at 8:52 pm. Level 179mg/dl. 4 units of insulin were administered. -5/8/24 - BS scheduled at 11:30 am and was checked at 1:49 pm. Level 168mg/dl. 2 units of insulin were administered. -5/8/24 - BS scheduled at 4:30 pm and was checked at 8:23 pm. Level 144mg/dl. -5/09/24 - BS scheduled at 6:30 am and checked at 6:41 am. Level at 61mg/dl. -5/12/24 - BS scheduled at 11:30 am and checked at 2:12 pm. Level at 400 mg/dl. 12 units of Novolin R administered. A review of Resident 5 ' s admission record indicated the resident was admitted on [DATE] with diagnoses including, diabetes type 2 (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), cardiomyopathy (disorder that affects the heart muscle and causes the heart to lose its ability to pump blood well. In some cases, the heart rhythm also becomes disturbed. This leads to arrhythmias [irregular heartbeats]) and hyperlipidemia (high levels of fats (lipids) in the blood which can increase the risk of heart attack and stroke because blood can't flow through the arteries easily). A review of Resident 5 ' s care plan dated 4/2/24 indicated, Resident 5 had was at risk for hyperglycemia or hypoglycemia r/t DM with a goal of keeping BS within normal limits. The interventions included BS monitoring and labs as ordered. A review of Resident 5 ' s MDS dated [DATE], indicated Resident 5 was cognitively intact (has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment) required between supervision or touching assistance to substantial/maximal assistance for all ADLs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the MAR audit between 5/7/24 to 5/14/24 indicated the following: - 5/9/24-BS scheduled at 4:30 pm and was checked at 9:23 pm. Level 159mg/dl. 2 units of insulin aspart administered. - 5/9/24 - BS scheduled at 4:30 pm, checked at 7:38 pm. Level 219 mg/dl 4 units insulin aspart administered. - 5/11/24 - BS scheduled at 11:30 am and was checked at 2:47 pm. Level 329mg/dl. 10 units of insulin were administered. - 5/11/24 - BS scheduled at 9 pm and was checked at 10:07 pm. Level 195mg/dl. 2 units of insulin were administered. A review of Resident 6 's admission record indicated the resident was admitted on [DATE] with diagnoses including, diabetes type 2 (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), metabolic encephalopathy (a series of neurological disorders not caused by primary structural abnormalities; rather, they result from systemic illness, such as diabetes, liver disease, renal failure and heart failure), and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves. People with schizophrenia may seem like they have lost touch with reality, which can be distressing for them and for their family and friends). A review of Resident 6 's care plan titled DIABETES MELLITUS, dated 1/31/24 indicated, Resident 6 had was at risk for hyperglycemia or hypoglycemia r/t DM with a goal of BS remaining within normal levels of 65-120 mg/dl. The interventions included BS monitoring and labs as ordered. A review of Resident 6 's MDS dated [DATE], indicated Resident 6 was cognitively intact (has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment) required between supervision or touching assistance to setup or clean-up assistance for all ADLs. A review of the MAR audit between 5/7/24 to 5/14/24 indicated the following: -5/11/24-BS scheduled at 9 pm and was checked on 5/11/24 at 12:21 am. Level 124mg/dl. A review of Resident 7 ' s admission record indicated the resident was admitted on [DATE] with diagnoses including, diabetes type 2 (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), and 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). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 7 's care plan titled DIABETES MELLITUS, dated 10/18/23 indicated, Resident 6 had was at risk for hyperglycemia or hypoglycemia r/t DM with a goal of BS remaining within normal levels of 65-120 mg/dl. The interventions included BS monitoring and labs as ordered. A review of Resident 7 's MDS dated [DATE], indicated Resident 7 was had severe cognitive impairment and required between supervision or touching assistance to partial/moderate assistance for all ADLs. A review of the MAR audit between 5/7/24 to 5/14/24 indicated the following: -5/8/24-BS scheduled at 4:30 pm and was checked at 10:43 pm. Level 147mg/dl. - No BS checked for 9 pm. - 5/9/24-BS scheduled at 4:30 pm and was checked at 10:11 pm. Level 231mg/dl. 2 units of insulin administered. -5/9/24-BS scheduled at 9 pm and was checked at 10:13 pm. Level 177mg/dl. No insulin administered. -5/10/24-BS scheduled at 4:30 pm and was checked at 7:29 pm. Level 163mg/dl. No insulin was administered. A review of Resident 7 ' s admission record indicated the resident was admitted on [DATE] with diagnoses including, diabetes type 2 (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), metabolic encephalopathy (a series of neurological disorders not caused by primary structural abnormalities; rather, they result from systemic illness, such as diabetes, liver disease, renal failure and heart failure), and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves. People with schizophrenia may seem like they have lost touch with reality, which can be distressing for them and for their family and friends). A review of Resident 7 ' s care plan titled DIABETES MELLITUS, dated 1/31/24 indicated, Resident 7 had was at risk for hyperglycemia or hypoglycemia r/t DM with a goal of BS remaining within normal levels of 65-120 mg/dl. The interventions included BS monitoring and labs as ordered. A review of Resident 7 ' s MDS dated [DATE], indicated Resident 7 was cognitively intact (has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment) required between supervision or touching assistance to setup or clean-up assistance for all ADLs. A review of the MAR audit between 5/7/24 to 5/14/24 indicated the following: -5/11/24-BS scheduled at 9 pm and was checked on 5/11/24 at 12:21 am. Level 124mg/dl. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 8 ' s admission record indicated the resident was admitted on [DATE] with diagnoses including, diabetes type 2 (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), secondary parkinsonism (when symptoms similar to Parkinson disease [a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves] are caused by certain medicines, a different nervous system disorder, or another illness), and hyperlipidemia (high levels of fats (lipids) in the blood which can increase the risk of heart attack and stroke because blood can't flow through the arteries easily). A review of Resident 8 ' s care plan titled DIABETES MELLITUS, dated 11/7/22 indicated, Resident 8 had was at risk for hyperglycemia or hypoglycemia r/t DM with a goal of BS below 65-120 mg/dl. The interventions included taking medication glipizide as ordered (belongs to a class of drugs called sulfonylureas. It stimulates the release of insulin from the pancreas, directing your body to store blood sugar. This helps lower blood sugar and restore the way you use food to make energy). A review of Resident 8 ' s MDS dated [DATE], indicated Resident 8 was had mild cognitive impairment and required partial/moderate assistance for all ADLs. There were no orders for blood glucose monitoring. During an interview and record review of Resident 9 ' s Medical Record Administration Record (MAR-includes key information about the individual's medication including, the medication name, dose taken, special instructions and date and time.) with Licensed Vocational Nurse (LVN) 1 on 5/8/24 at 10:07 pm, LVN stated that his shift starts at 7 am and admitted that he had reported to work at 8:30 am. LVN 1 admitted that he had been coming in to start shift between 8:30 am and 10 am. LVN 1 stated the morning medication are schedule at 9 am. LVN 1 stated that the facility policy allows medications to be passed an hour before and an hour after which gives a window between 8 am and 10 am. LVN 1 stated that medication pass lasts between one to two hours and admitted that starting them later than 8 am could result in late medication administration. Resident 9 ' s MAR indicated the following medications had not been administered: 1. Baclofen (a muscle relaxer used to treat muscle symptoms like spasms, pain, and stiffness.) 10 milligrams (mg), take 1 tablet (tab) by mouth (three times a day. 2. Amlodipine (used alone or in combination with other medications to treat high blood pressure in adults and children) 10 mg, take po daily. 3. Seroquel (used to treat certain mental/mood disorders) 100mg, take one-tab po for schizophrenia. During an interview with Resident 9 on 5/8/24 at 10:21 am, Resident he had not received his morning medications yet. Record review of LVN 1 ' s time card for the month of May 2024 indicated, out of the 5 days that LVN 1 was scheduled to start his shift at 7 am he clocked in at the following times: 5/1/24 - 9:41 am 5/2/24 - 9:36 am (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/3/24 - 10 am 5/7/24 - 9:53 am 5/8/24 - 8:26 am. During an interview with the Minimal Data Set Nurse (MDS 1) on 5/8/24 at 2:15 pm, MDS 1 stated that she oversaw scheduling the nursing assignments as well as ensuring coverage for late minute call ins or late calls. MDS 1 was did not want to state what was considered late/[NAME]. MDS 1 stated that the facility was not concerned about checking tardiness unless a resident complained. MDS 1 stated the potential effect of coming in late is that medications will be administered late to the residents. The risk of late medication administration could result in worsening of residents conditions such as elevated Blood Pressure (BP) if BP meds not administered when ordered. During an interview with the administrator on 5/8/24 at 4:23 pm, the administrator stated that she (administrator) had identified that LVN 1 was coming in to work late sometime year. The administrator admitted that there was no documented evidence of an intervention plan or follow up. During a concurrent observation and interview with LVN 2 on 5/8/24 at 5:55 pm, LVN 2 was observed reporting on the unit for work. LVN 2 admitted that he was late and that medications scheduled for 5 pm would now be overdue. LVN 2 stated that he had 6 residents who needed to have their blood sugar checked had already had their dinner. LVN 2 stated that he would check it after their dinner. LVN 2 stated that the order for FS was before meals. During an interview with the MDS 1 on 5/8/24 at 6:17 pm, MDS 1 admitted that she was made aware that LVN 2 was coming in late for his shift (3 - 11 pm) and that there was no coverage brought in to cover his (LVN 2) assignment. MDS 1 confirmed that checking BSs and administering medications later than they were ordered for is considered a medication error. During a concurrent interview and record review with Registered Nurse supervisor (RNS 2) on 5/13/24 at 11:40 am, RNS stated BS must be checked before meals as ordered by the physician to prevent getting inaccurate readings which may indicate hyperglycemia (numbers greater than 180). RNS stated that those numbers maybe misleading for physician ' s reviewing them as they may end up ordering more insulin which may lead to hypoglycemia, hospitalization s, diabetic coma, or death. During an interview with LVN 2 on 5/14/24 at 12:25 pm, LVN 2 admitted that he had been checking BS levels after meals especially on days that he reported late for work even though the orders indicated to check before meals. LVN 2 confirmed that he gave insulin based on the BS levels and that he did not feel that it was not necessary to inform the physician that the BS was not checked per their orders. LVN 2 was unable to explain the implications of administering short acting insulin hours after dinner right before bedtime. During an interview with RNS on 5/14/24 at 2:38 pm, RNS 2 stated that the physician should have been notified every time the BS was checked late and also for each instance the insulin sliding scale was based on BS levels checked after residents already had their meals. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on interview and record review, the facility failed to ensure appropriate competencies to provide nursing and related services to assure resident safety by failing to: 1. Maintain and update basic life support/ Cardiopulmonary Resuscitation (BLS/CPR) certification to one of six sampled facility staff (Minimum Data Set Nurse 1[MDS1]). 2. Ensure two of six sampled facility staff (Licensed Vocational Nurse 2 [LVN2], and Licensed Vocational Nurse 9[LVN9]) had the specific competencies and skill sets necessary to care for the residents in the facility. These deficient practices had the potential to place resident at risk of not getting proper immediate care during a life-threatening situation. Findings: During a concurrent interview and record review with the Director of Staff Development (DSD) on [DATE] at 5:31 p.m., all six sampled staff files were reviewed. Staff files indicated that MDS1 was missing an updated BLS/CPR. Staff files also indicated that LVN2 and LVN9 was missing skills check competencies. DSD stated that staff files should be updated especially BLS/CPR and the skills check competencies. DSD also stated that skills check must be done to all the nursing staff upon hire, annually and as needed. A review of facility policy and procedures (P&P), titled, Competency of Nursing Staff, reviewed on [DATE], P&P indicated that licensed nurses will participate in a facility-specific competency-based staff development and training program and demonstrate specific competencies and skills set deemed necessary to care for the needs of residents. A review of facility P&P, titled, Emergency Procedure-Cardiopulmonary Resuscitation, reviewed on [DATE], P&P indicated that staff will obtain and maintain certification in BLS/CPR for key clinical staff members who will direct resuscitative efforts, including non-licensed personnel.