

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Miracle Mile Healthcare Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44252</p> <p>Based on interview and record review, the facility failed ensure medical record for two of four sampled residents (Resident 1 and 3) was accurate and complete for:</p> <ol style="list-style-type: none"> <li>1. Resident 1's Medication Administration Record (MAR),</li> <li>2. Resident 1 and 3's informed consent (resident's authorization to receive treatments or medications after risks and benefits are discussed by physician, physician's assistant, or nurse practitioner) form.</li> </ol> <p>These failures resulted in an inaccurate and incomplete medical record and informed consent forms. for Resident 1 and 3.</p> <p>Findings:</p> <p>1. A review of Resident 1's Face sheet (summary of residents personal and demographic information, cover sheet of the medical record) dated 6/7/24, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including cerebral palsy (abnormal brain development before birth with loss of motor function), muscle wasting and atrophy (decrease in size), schizophrenia (mental illness that affects how a person thinks, feels, and behaves), and anxiety (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) disorder.</p> <p>A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and screening tool), dated 2/12/24, indicated, Resident 1 mild memory problems. The same MDS further indicated Resident 1 required supervision to partial/moderate assistance from one staff for eating, oral hygiene, toilet use, bathing, dressing, personal hygiene, bed mobility and transfers.</p> <p>A review of Resident 1's Medication Administration Record (MAR), dated 4/2024, indicated the following missing entries in documentation:</p> <p>a. Diet mechanical soft, chopped with thin liquids missing entries on 4/12/24 at 5:00 pm, 4/14/24 at 12:00 pm and 5:00pm, 4/15/24 at 7:00 am, 12:00 pm and 5:00 pm.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Risperdal (medication used for schizophrenia) 1 milligram (mg, metric unit of measure) 1 tablet by mouth twice a day, missing entries on: 4/16/24 at 5:00 pm, 4/15/24 at 9:00 am and 5:00 pm, and 4/16/24 at 5:00 pm.</p> <p>c. Multivitamin with minerals tablet (vitamin supplement) 1 tablet by mouth one time a day, missing entry on: 4/15/24 at 5:00 pm.</p> <p>d. Ortho Tri-cyclen (medication for birth control) 28 tablet 1 tablet by mouth daily, missing entry on: 4/15/24 at 5:00 pm.</p> <p>e. Anti-psychotic (drug used to treat psychotic disorders): monitor side effects every shift, missing entries on: 4/14/24 for evening and night shift, 4/15/24 for day, evening, and night shift, 4/1/24 for evening and night shift.</p> <p>f. Monitor for schizophrenia manifested by fecal (stool/ waste) smearing every shift and indicate total number of behaviors, missing entries on: 4/14/24 for evening and night shift, 4/15/24 for day, evening, and night shift, 4/1/24 for evening and night shift.</p> <p>g. Pain assessment: monitor every shift using the pain description scale, missing entries on: 4/14/24 for evening and night shift, 4/15/24 for day, evening, and night shift, 4/1/24 for evening and night shift.</p> <p>A review of Resident 1's Physicians Orders, dated 4/2024, indicated an order for Risperdal 1 mg tablet give 1 tablet by mouth twice a day for schizophrenia manifested by fecal smearing informed consent obtained by MD (Medical Doctor) from responsible party.</p> <p>During an interview with concurrent record review with the ADON on 6/20/24 at 3:05 pm, Resident 1's Informed Consent and Verification of Informed Consent forms were reviewed. Resident 1's Informed Consent form, undated, indicated, Risperdal 2 mg by mouth twice a day, the ADON confirmed the consent form was missing name and signature and date of MD or NP who obtained informed consent, and that the Verification of Informed Consent form was missing a signature of the nurse verifying consent and date. The ADON stated complete documentation is the way to prove it was done.</p> <p>During the same interview with concurrent record review with the Assistant Director of Nursing (ADON) of Resident 1's Medication Administration Record (MAR) on 6/20/24 at 3:05 pm, the ADON confirmed there were gaps in the documentation on Resident 1's MAR. ADON stated, if it is not documented we would not know if the resident received the medications or services, it's the way to prove it was done.</p> <p>A review of the facility's policy and procedures titled Charting and Documentation, reviewed 1/25/24, indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record . documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. A review of Resident 3's Face sheet dated 6/7/24, indicated Resident 3 was admitted to the facility on [DATE], with diagnoses muscle wasting and atrophy (decrease in size), schizoaffective disorder (mental health condition including schizophrenia and mood disorder symptoms), and hypertensive (high blood pressure) heart disease with heart failure (a condition in which the heart doesn't pump blood as well as it should) and anemia (A condition in which the blood doesn't have enough healthy red blood cells, to carry oxygen all through the body).</p> <p>A review of Resident 3's MDS, dated [DATE], indicated, Resident 3 was cognitively (the way one thinks, reasons, and remembers) intact. The same MDS further indicated Resident 3 required setup or clean-up to partial/moderate assistance from one staff for eating, oral hygiene, toilet use, bathing, dressing, personal hygiene, bed mobility and transfers.</p> <p>A review of Resident 3's Physicians Orders, dated 6/2024, indicated an order for Seroquel 25 mg tablet give 1 tablet by mouth daily for schizoaffective disorder manifested by aggression towards staff, informed consent obtained by MD/NP (Medical Doctor/ Nurse Practitioner) from responsible party. Further review of the same Physicians Orders indicated Aripiprazole 10 mg tablet give 1 tablet by mouth daily for schizoaffective disorder manifested by sudden angry outbursts, informed consent obtained by MD/NP from responsible party.</p> <p>During an interview with concurrent record review with the ADON on 6/20/24 at 3:05 pm, Resident 3's Informed Consent and Verification of Informed Consent forms were reviewed. Resident 3's Informed Consent forms, undated, indicated, Seroquel 25 mg tablet give 1 tablet by mouth daily for schizoaffective disorder manifested by aggression towards staff and Aripiprazole 10 mg tablet by mouth daily for schizoaffective disorder manifested by sudden outburst of anger, respectively the ADON confirmed the consent forms were both missing the date signed by MD who obtained informed consent. The ADON stated complete documentation is the way to prove it was done.</p> <p>A review of the facility's policy and procedures titled Charting and Documentation, reviewed 1/25/24, indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record . documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.</p>		