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	09/19/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on interview and record review the facility failed to implement fall prevention measures by monitoring for the effectiveness of the interventions and modify the interventions based on the needs of the resident to prevent recurrent falls and injury for one of three sampled residents (Resident 1). This deficient practice resulted in Resident 1 having multiple falls on 10/10/23, 11/20/23, 2/25/24, 5/24/24, 7/5/24, and 8/21/24. On 8/21/24 at 5:25 pm, Resident 1 had a fall and was transferred to a general acute care hospital (GACH) via 911 (emergency response telephone number), where Resident 1 with a traumatic head injury (injury to the head acquired from an outside force, usually a violent blow) resulting in a left subdural (area between the brain and skull) hematoma (a collection of blood outside of blood vessels usually caused by injury or surgery that damages the blood vessels) and nondisplaced (connected) left 3rd to 6th rib fractures. GACH admitted Resident 1 to the Intensive Care Unit (ICU, a special department or unit of a hospital or health care facility that provides intensive care medicine, for patients that are seriously ill), for further management and care. Findings: During a review of Resident 1's Admission Record dated 9/10/24, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (a condition affecting the brain due to a chemical imbalance in the blood), dementia (a condition of the brain that causes memory loss, confusion, trouble finding, words, misjudging distances and problems performing familiar tasks) with other behavioral disturbance, aphasia (a condition involving language, effecting the ability to communicate) following cerebral infarction (stroke), impulse disorder (behavioral conditions affecting the way one controls their actions and reactions) , and epilepsy (seizure disorder). During a review of Resident 1's fall risk assessment dated [DATE], indicated Resident 1 had a score of 14 (a score of 10 or above represents high risk for fall). The fall assessment further indicated Resident 1 had balance problems while standing, balance problems while walking, decreased muscular coordination, and used of assistive devices for mobility. (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's fall risk care plan dated 9/19/23, indicated Resident at risk for fall due to recent fall, use of psychotropic medication (drugs that affect mood, thoughts and behaviors used to treat mental illness), balance problem, and poor safety awareness. The same care plan further indicated prevention interventions included, to place the call light within reach and staff to answer/respond to the residents call lights promptly. The same care plan indicated to maintain safe environment, room free of cluster, remind resident to use assistive device, toileting schedule, refer to PT (physical therapy, treatment that to help manage pain, improve movement, regain strength after surgery)/OT (occupational therapy, treatment that helps people overcome physical, sensory or cognitive problems, with basic tasks people do every day to care for themselves e.g., grooming, dressing), lap buddy (cushioned device that fits the wheelchair and assists with reminding a persona not to get up by themselves) in wheelchair check and release every two hours and reposition, keep frequently used items within reach, siderails/padded as per Medical Doctor (MD) order. During a review of Resident 1's Short Term Care Plan for status post (after) fall (10/10/23) left leg pain initiated on 10/10/23 indicated interventions included to monitor the resident for 72 hours, notify MD, notify Resident 1's family responsible party (RP) and STAT (without delay) x-ray. During a review of Resident 1's Interdisciplinary Team (IDT, a meeting where team members from different heads of department get together and plan and review resident's care) meeting notes dated 11/20/23 indicated resident is impulsive continues to get up unassisted due to impaired cognition. Frequent urge to get up unassisted. Reinforce use of call light. During a review of Resident 1's Care Plan Short Term Fall and Incidence dated 11/29/23, indicated interventions of: provide safe environment at all times, encourage resident to use call light and an intervention written in by hand but illegible. During a review of Resident 1's Care Plan Short Term Fall and Incidence dated 2/25/24, indicated Resident 1 was found on floor going to/coming from bathroom transferring self without nursing assistance on 2/25/204 at 8 am. The care plan further indicated interventions included to provide the resident with a safe environment at all times, handle gently, encourage resident to use call light for all needs, provide resident with free of cluster, place all personal belongings within reach, encourage resident to ask for assistance from staff for all transfers (to and from wheelchair, bed, etc.), anticipate resident need to use the restroom, neurological check (neurological exam, a way to evaluate a patient's nervous system, to detect threatening conditions) for 72 hours, monitor for pain every shift. During a review of Resident 1's Fall Risk care plan dated 2/25/24, indicated, Resident 1 was at risk for fall related to dementia, impulse control disorder, and epilepsy, recent fall, history of multiple falls, balance problem, memory problem, poor safety awareness and refuses to use call light. The care plan further indicated interventions included to place the call light within the resident's reach and staff to answer the call light promptly. The care plan further indicated to encourage the resident to call for assistance if needed, maintain a safe environment, the resident's room be free of clutter, assist with ADLs (Activities of Daily Living) as needed, and to remind the resident to use assistive device, monitor for adverse side effect (ASE, undesirable or harmful effect) from medications. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's IDT meeting notes dated 2/26/24 indicated no injury, fell when coming from bathroom. Resident 1 is being closely monitored by staff, grouped in a room with roommates on closed monitoring meaning the other two residents were being monitored by sitter (healthcare worker who provides care and support to patients: by monitoring, assisting, providing safety, and/or companionship). During a review of Resident 1's Fall Risk care plan with a revision date on 2/25/24 indicated status post fall (2/25/24) resident is move close to nursing station and on close supervision. During a review of Resident 1's Nursing Progress Note dated 2/26/24, Licensed Vocational Nurse (LVN) indicated that on 2/25/24 at 8 am Resident 1 had slid out of his wheelchair while transferring self, coming from the bathroom. The nursing progress note further indicated the resident's Responsible Party (RP, is the individual or entity that has the legal control, manages, or directs the entity and the disposition of the entity's funds and assets, and at least [AGE] years older) had requested a sitter nurse to monitor Resident 1 because he has dementia and has fallen multiple times. The LVN documented that staff were encouraging Resident 1 to ask for assistance with all transfers even if the resident believed he could transfer himself. The nursing progress note further indicated RP again mentioned Resident 1 had dementia and cannot remember to use the call light (to call for assistance) and could barely remember anyone's name. The nursing progress note further indicated RP was offered to have a pad alarm (pressure-sensitive pad that can be placed under a person in bed or chair, which will alarm when the person starts getting up) placed on the resident's wheelchair for safety but was told that Resident 1 did not qualify for a sitter. The nursing progress note indicated that RP is tired of Resident 1 falling and that RP would feel bad if the resident was to die, break a hip, or hurt himself from falling. During a review of Resident 1's Physician Orders dated 3/4/2024, indicated for pad alarm on bed while Resident 1 is in bed to alert nursing staff when the resident is attempting to get out of bed by self, apply pad alarm on wheelchair while resident is in wheelchair to alert nursing staff when resident is attempting to get out of wheelchair by self, wheelchair and monitor pad alarm placement and functioning/mark ON is Pad Alarm is in place and functioning/mark OFF if pad Alarm is not in place and not functioning. During a review of Resident 1's Fall Risk care plan for the fall on 3/4/24, indicated no revision was indicated for the use of the tab or pad alarm, or interventions indicated for the behaviors of the resident removing the tab or pad alarm. During a review of Resident 1's Renew SBAR form (Situation, Background, Assessment, and Recommendation, used to communication critical information in a change of condition) dated 3/4/24, indicated Resident 1 was having multiple episodes of taking/removing the tab alarm. The SBAR indicated that staff were conducting rounds to visually monitor Resident 1 who was a high fall risk. The SBAR indicated the resident was refusing the tab alarm (alarm connected to resident's clothes that will monitor movement) and change of tab alarm (a personal alarm clipped to person's garment, which will alarm when pulled) to pad alarm. During a review of Resident 1's Renew SBAR dated 5/24/24 at 5:50 pm, indicated Resident 1 had fall, witnessed by a staff who reported that the resident is on the floor sitting down beside his bed, and resident stated he was trying to get up on the wheelchair and lost balance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Fall Risk care plan for the fall on 5/24/24, no revision was indicated after the fall on 5/24/24. During a review of Resident 1's Short Term Care Plan dated 6/3/24, indicated, change of condition (COC - significant decline or improvement in their health that requires intervention) status post fall on 5/24/24, with interventions to monitor Resident 1 for 72 hours, notify MD, and notify family/RP. No new interventions noted. During a review of Resident 1's Minimum Data Set (MDS a standardized assessment and care screening tool) dated 6/25/24, indicated Resident 1 had a moderately impaired (confusion about where one is and what is happening) cognition (ability to think, understand and make daily decisions). Resident 1's MDS further indicated Resident 1 required supervision or touching assistance, where a helper provides verbal cures and/ or touching/ steadying and/or contact guard assistance as resident completes activity; for toileting, sit to lying, sit to stand, chair to chair transfer, and toilet transfer. During a review of Resident 1's Renew SBAR dated 7/7/24 at 4:30 pm, indicated, RP visited Resident 1 today (7/7/2024) and informed a Registered Nurse (RN) that on 7/5/24 at around 11:20 pm while sleeping, Resident 1 fell , rolled out of bed, complained of intermittent rib pain during inspiration (breathing in), and an x-ray was ordered. During a review of Resident 1's Incident of fall care plan dated 7/7/24 indicated, [Resident 1] claimed he fell on Friday 7/5/24 at 11:20 pm. The incident of fall indicated the resident stated he was asleep and rolled out of bed on the right side, and reported incident to RP. The care plan interventions included, monitor vital signs, medicate for pain, rehabilitation (restoring someone to health or normal life through training and therapy) post fall assessment, keep environment free of hazards ., place call light within reach, answer promptly, keep frequently used items within reach, discuss, with resident the necessity for use of preventative equipment to ensure safety, bed in lock position, fall precaution every shift x-ray will report the result to MD. During a review of Resident 1's SBAR Communication Form dated 8/21/24, indicated Resident 1 had an unwitnessed fall (8/21/24 at 5:25 pm) and was noted on the floor lying on the floor on his back with his head against the wall, bed in lowest position, skin intact, no visible injuries, resident stated he felt dizzy due to fall and was immobilized until paramedics arrived. During a review of Resident 1's care plan titled Post Unwitnessed Fall dated 8/21/24 indicated interventions including, check range of motion, continue interventions on the at-risk plan, monitoring and report change in status pain bruises, new onset confusion, sleepiness, inability to maintain posture, agitation, neuro (means nerve and nervous system) checks for 72 hours, resident transferred to a GACH. During a review of GACH Emergency Department (ED) Provider Note dated 8/21/2024 at 11:43 pm, indicated Resident 1 with a witnessed non-syncopal (without loss of consciousness) fall with head trauma and back pain. The ED provider note indicated computed tomography scan (CT scan-is a medical imaging technique used to obtain detailed internal images of the body) brain, c-spine (neck region of your backbone, spinal column) . ordered. The ED provider note indicated Resident 1 diagnoses included traumatic injury of the head initial encounter. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of GACH Neurocritical (pertaining to intensive care management of patients with life-threatening neurological and neurosurgical illnesses such as massive stroke, bleeding in or around the brain) Progress Note dated 8/22/2024 indicated Resident 1 complained of headache and back pain (pain level for both not documented). The neurocritical progress note indicated that the CT imaging for Resident 1, Revealed 10 millimeter (mm-unit of measurement) left (L) parasagittal (situated alongside of or adjacent to) subdural hematoma (SDH), 15mm acute (of sudden onset) L tentorial (a tent-shaped duplicated fold) SDH, 8mm acute L hemispheric (relating to, or involving one of the two parts of the brain) SDH, trace left middle cranial fossa (a depression, commonly it refers to bones) subarachnoid hemorrhage (bleeding) with 15mm rightward midline shift. He [Resident 1] is admitted to the Neuro ICU for close neurologic monitoring. In addition . patient (pt- Resident 1) was also found with subacute nondisplaced L 3rd-6th rib fractures . The neurocritical progress note indicated Resident 1 was awake and oriented to self and place . During a review of GACH CT Brain for Resident 1 dated 8/22/2024 at 5:11 am, indicated the following: 1. The ventricular system was moderately enlarged with right midline shift measuring 6.62 mm . 2. Acute left parasagittal subdural hematoma measuring 8.5 mm 3. Acute left tentorial subdural hematoma measuring up to 14.1 mm, 4. Acute left hemispheric subdural hematoma extending toward frontal lobe measuring up to 8.8 mm 5. Small interval increase in left hemispheric subdural hematoma. 6. Small subarachnoid hemorrhage in temporal lobe measuring 2.5 mm During a review of Resident 1 GACH physician progress note dated 8/22/24 at 6:51 am indicated, Resident 1 was admitted to ICU on 8/21/24 with a traumatic brain injury, subdural hematoma, subarachnoid hemorrhage, and multiple fracture of ribs (initial encounter for closed fracture) on the left side. During a review of GACH CT Brain for Resident 1 dated 8/22/2024 at 4:25 am, indicated Resident 1 had Large left hemispheric mixed attenuating subdural hematoma is noted measuring up to 29 mm. Blood products along the interhemispheric falx (sickle-shaped structure along the longitudinal slit separating the two hemispheres of the brain) is noted . Midline shift to the right measures 14 mm . Actionable Finding: Urgent . During a review of GACH Internal Medicine Progress Note dated 8/24/2024 at 12:48 pm, indicated Resident 1 Became unresponsive and L pupil became sluggish (slow to react). CT Head (CTH) showed worsening left hemispheric subdural hematoma with worsening midline shift to the left. Patient (pt) [Resident 1] was urgently intubated (a process where a healthcare provider inserts a tube through a person's mouth or nose, then down into their trachea (airway/windpipe) and taken to operating room (OR) for craniotomy (the surgical removal of part of the bone from the skull to expose the brain) . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/10/24 at 11:10 am with Licensed Vocational Nurse (LVN) 1, LVN 1 stated interventions to prevent falls included the call light be within reach, bed in low position, maybe fall mats at the bedside after a fall, and if the resident is non-compliant, then a sitter (staff to assist resident who need additional supervision and / or companionship). LVN 1 further stated Resident 1 needed assistance with transfers, used a wheelchair and had fallen recently. During an interview on 9/10/24 at 3:21 pm with Certified Nursing Assistant (CNA) 1, CNA 1 stated he was aware Resident 1 had a fall and there was no sitter assigned to the resident the day the resident fell . CNA 1 further stated nurses are informed during the morning stand up meeting of residents at high fall risk. During a telephone interview on 9/16/24 at 4:59 pm with Sitter 2, Sitter 2 stated, she was in the room when Resident 1 fell , and was assigned as a sitter for the two other residents in the same room as Resident 1. Sitter 2 stated she was assisting one of the two residents in the room and saw Resident 1 stand. Sitter 2 stated she asked Resident 1 if the resident needed help and the resident told Sitter 2, he was OK. Sitter 2 stated she was dealing with an agitated resident [Resident 1's roommate] and when Sitter 2 turned to look again to look at Resident 1, Resident 1 on the floor on the back with the head up against the wall in between the bed and the wall. Sitter 2 further stated she yelled for help and staff came to assess the Resident 1. Sitter 2 stated 911 was called, and Resident 1 was immobilized until the paramedics arrived. Sitter 2 further stated Resident 1's fall could have been avoided had the resident had a one-to-one sitter. During an interview on 9/19/24 at 12:58 pm, with CNA 2, CNA 2 stated he was aware Resident 1 fell but was not aware the resident was a high fall risk or had fallen before. CNA 2 further stated Resident 1's bed was in the normal position the day the resident fell and there were no fall mats at the bedside. CNA 2 stated it looked like the resident fell back into the wall when getting out of the wheelchair after dinner to get back into bed. During an interview on 9/19/24 at 1:30 pm with Medical Records Director (MRD), the MRD stated all the care plans and records related to Resident 1's falls were provided. During a telephone interview on 9/19/24 at 2:05 pm with Registered Nurse (RN) 1, RN 1 stated Resident 1 was a fall risk, and the resident's room was close to the nursing station for closer monitoring. RN 1 stated the resident would not use the call light or call for assistance, and that there were no other interventions in place to the resident from repeated falls. RN 1 further stated she was unaware the resident had previous falls and to qualify for a sitter a resident would have to have behaviors, be a fall risk non-complaint with interventions. During a telephone interview on 9/19/24 at 2:20 pm with LVN 3, LVN 3 stated she was unaware Resident 1 had fallen before, was aware the resident was quiet and would be in the wheelchair and that the resident had shaky legs. LVN 3 stated, If he [Resident 1] had fallen before, they would have to have put him [Resident 1] on a sitter, because that would have been high, high risk (for falls). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's policy and procedures (P&P) titled Falls and Fall Risk, managing dated 1/25/24, the P&P indicated, fall risk factors environmental . incorrect bed height or width . resident conditions . other cognitive impairment, pain, lower extremity weakness, medication side effects . medical factors . balance and gait disorders. Resident-centered approaches to managing falls and fall risk . staff with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls . if falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. Monitoring subsequent falls and fall risk . The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling . If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed . If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. During a review of the facility's P&P titled 1:1 Supervision/Sitters undated, the P&P indicated, Purpose to assist resident who need additional supervision and/or companionship in obtaining sitters or companion care. The facility will hire, train, and provide monitoring aides to those residents in need of extra supervision due to their medical, physical, or psychosocial wellbeing in accordance with IDT (Interdisciplinary Team) assessment.