

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 09/27/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45037</p> <p>Based on observation, interview, and record review, the facility failed to provide two-person assist with Activities of Daily Living (ADL, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) care for one of three sampled residents (Resident 1).</p> <p>These deficient practices resulted in Resident 1 falling to the floor during ADL care, was transferred to a general acute care hospital (GACH) sustaining a sprain to her left ankle.</p> <p>Findings:</p> <p>During a review of Resident 1's admission record indicated Resident 1 was re-readmitted to the facility on [DATE], with a diagnoses including cerebral palsy (a group of neurological disorders that appear in infancy or early childhood and permanently affects body movement and muscle coordination), muscle wasting (a weakening, shrinking, and loss of muscle caused by disease or lack of use), and osteoporosis (a bone disease that develops when bone mineral density and bone mass decreases).</p> <p>During a review of Resident 1's History and Physical dated 4/7/24, indicated Resident 1 has the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/28/24, indicated Resident 1 has a BIM (Brief Interview for Mental Status) score of 15. The same MDS further indicates that Resident 1 required moderate to maximum assistance with ADL care.</p> <p>During an interview with Resident 1 on 9/26/24 at 10:30am, Resident 1 stated on the night of the incident (9/12/24 around 7:30pm), Certified Nurse Assistant (CNA) 3 did not use a second nurse to assist with her ADL care. Resident 1 stated CNA 3 worked 3-11 shift. Resident 1 stated CNA 3 was familiar with her because CNA 3 was her regular CNA. Resident 1 further stated that CNA 3 rolled her over very quickly to her left side and she fell on the floor and her left foot was underneath her body. Resident 1 stated the CNA 3 supported her head so that it would not hit the floor. Resident 1 stated she was transferred to GACH. Resident 1 stated she sustained a sprain to her left ankle. Resident 1 stated she was sad and upset that the CNA 3 did this to her. Resident 1 stated that CNA 3 knew she was a two person assist since being admitted to the facility. Resident 1 stated she received a brace for her left ankle, however she refuses to wear it until her ankle was no longer sore.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/26/24 at 2:53 p.m., CNA 1 stated she was the nurse for Resident 1 today. CNA 1 stated she was very familiar with Resident 1. CNA 1 confirmed and stated that Resident 1 has always had a two-person assist at all times to prevent the resident from falling or getting injured.</p> <p>During an interview with on 9/26/24 at 3:54 p.m., CNA 3 stated she was the nurse working with Resident 1 on the night of the incident on 9/12/24. CNA 3 stated on the night of the incident, she turned her slowly to her left side after changing her and she is not sure how Resident 1 fell off the bed. CNA 3 stated she supported Resident 1's head to prevent her from hitting her head on the floor. CNA 3 stated Resident 1 complained of pain to her left ankle. CNA 3 further stated the fall could have been prevented if she would have called for assistance to change Resident 1.</p> <p>During a concurrent record review and interview on 9/26/24 at 2:23 p.m., RNS stated CNA 3 was the nurse for Resident 1 on the day of the incident. Stated the nurses are always supposed to do two-person assist when providing ADL care for Resident 1. RNS stated CNA 3 is fully aware that she is always to do two-person assist when providing ADL care for Resident 1. RNS stated CNA 3 was the regular CNA for Resident 1.</p> <p>During a review of the facility's policy and procedures titled Falls and Fall Risk, Managing dated 1/25/24, indicated the staff will identify interventions related to the resident's specific risk and causes to try to prevent the residents from falling and to try to minimize complications from falling.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45037</p> <p>Based on observation, interview, and record review, the facility failed to serve food consistent with the preferences of one of three sampled residents (Resident 2) who was noted to be allergic (occurs when a person's immune system reacts to substances in the environment that are harmless to most people) to coconut, when staff served Resident 2's food tray was noted with a piece of chocolate cake noted with coconut on it.</p> <p>This failure resulted to Resident 1's getting a piece of chocolate cake noted with coconut on it which was listed as food allergy.</p> <p>Findings:</p> <p>During a review of Resident 2's admission record indicated Resident 2 was readmitted to the facility on [DATE], with a diagnoses that included and not limited to chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems), heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), morbid obesity (if their weight is more than 80 to 100 pounds above their ideal body weight).</p> <p>During a review of Resident 2's History and Physical dated 9/13/24, indicated Resident 1 has the capacity to understand and make decisions, and have an allergy to coconut.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/28/24, indicated Resident 1 has a BIM (Brief Interview for Mental Status) score of 15. It further indicates that Resident 1 need moderate to maximum assistance with Activities of Daily Living (ADLs, routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 1's careplan dated 9/26/24, indicated Resident 1 has an allergy to coconut.</p> <p>During a concurrent observation and interview on 9/26/24 at 11:24am, Resident 2's food tray noted a piece of chocolate cake noted with coconut on it. Resident 2 stated the food in the facility was not good and they need to switch the food menus sometimes. Resident 2 stated the kitchen always give her an adequate amount of food with every meal. Stated today for lunch the kitchen gave her a piece of cake with coconut on it. Resident 2 stated the kitchen staff was aware of her allergies to coconut. Resident 2 further stated giving me food with coconut on it made me very angry. Stated the kitchen staff is being very careless with giving me food that I am allergic to. Resident 2 stated if she consumes coconut, it causes her throat to swell and causes difficulty breathing.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/26/24 at 1:29 p.m., Certified Nurse Assistant (CNA) 2 stated she has been employed with the facility for 7 months. CNA 2 stated she was the nurse for Resident 2 today. CNA 2 stated she went to the kitchen to request for an alternate food tray for Resident 2. CNA 2 stated Resident 2 requested for 1 hotdog, chef salad, 1 orange juices, and 1 pieces of chocolate cake. CNA 2 stated the Licensed Vocational Nurses' (LVNs) usually check the food carts prior to the CNA's passing the food trays. CNA 2 stated she did not witness any of the LVN's check the food carts before the CNA's passed the food trays.</p> <p>During a concurrent interview and record review on 9/26/24 at 1:57 p.m., Registered Dietician (RD) stated she has been employed with the facility for 7 months. Resident 2's food tray card was reviewed. Resident 2's food tray card the allergies to coconut was highlighted in green indicating the allergies to coconut. A review of Resident 2's history and physical indicated Resident 2 had an allergy to coconut. The RD stated it was the kitchen staff responsibility to check the food trays prior to the food trays going to the floor to the residents. The RD stated if the kitchen staff do not check food tickets and food trays prior to the trays going to the floors can cause the residents to receive wrong foods which can cause harm to the residents especially if they have an allergy to certain foods. The RD stated she tried her best to accommodate the residents with foods of their choice, however, the kitchen staff was limited due to the amount of funds they are allowed to spend from the corporate office. The RD stated she has never gotten a report from the staff or a resident that the kitchen ran out of food to serve to the residents. RD stated all patient weight loss is addressed and reported to the physician.</p> <p>During a concurrent observation, interview and record review on 9/26/24 at 2:23 p.m., with the Registered Nurse Supervisor (RNS), Resident 2's food tray was observed, there was a piece of chocolate cake with coconut icing on the cake. R review of Residents 1,2, and 3's records indicated, there was no significant weight loss for Residents 1, 2, or 3. A review of Resident 2's physician orders indicated that Resident 2 was allergic to coconut. The food card from the food tray for Resident 2 indicated Resident 2 has an allergy to coconut was highlighted in green. The RNS stated he has been employed with the facility for 5 months. The RNS stated it was the treatment nurses' responsibility to check the food trays prior to the trays being given to the residents. RNS stated if the food trays are not checked by a license nurse the resident could be given foods that can be harmful to the residents. RNS stated CNA 3 was the nurse for Resident 1 on the day of the incident. Stated the nurses are always supposed to do two-person assist when providing ADL care for Resident 1. RNS stated CNA 3 is fully aware that she is always to do two-person assist when providing ADL care for Resident 1. RNS stated CNA 3 is the regular CNA for Resident 1. Stated if the residents are complaining about food choices, he will notify the dietary supervisor to follow up with the residents. RNS stated none of the staff or residents reported to him that the residents are not getting enough food. Stated the facility is not working short of staff that often. Stated if the nurses call of and the regular staff cannot work overtime the facility will utilize the registry staff.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and a concurrent record review on 9/26/24 at 3:34 p.m., with Dietary Supervisor (DS), Resident 2' food tray card was reviewed. The DS confirmed and stated, Resident 2 food tray card was highlighted in green indicated that Resident 2 was allergic to coconut. The DS stated she has been employed with the facility for two years. The DS stated it was the tray lines staff responsibility to check the tray cards and the food trays prior to the food being placed on the food carts. The DS stated if the food trays and tray cards are not checked properly the resident could receive foods that are harmful to them, wrong consistency, or have an allergy. The DS stated she reminds the dietary staff during morning huddle to always check the food tray cards prior to putting the food on the carts. DS stated none of the kitchen staff has ever reported to her that the kitchen ran out of food to feed the residents.</p> <p>During an interview on 9/26/24 at 3:15 p.m., the Treatment Nurse (TN) stated she was not informed by the DON, DSD, or the RNS that it was her responsibility to check the food trays prior to the nurses giving the food tray to the residents. The TN stated it was important to check the resident's food trays so that the residents are not receiving foods that can be harmful to them, make sure the resident gets the right food consistency. The TN further stated if a resident received food that they are allergic to they can have a reaction to the food such as rashes, difficulty breathing or even death.</p> <p>During a review of the facility's policy and procedures titled Food Allergies dated 1/25/24, indicated allergies will be noted on the tray card, the resident diet profile, and posted in the kitchen and nursing station if necessary.</p>		