

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 03/14/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252</p> <p>Based on interview and record review the facility failed to develop a care plan for history of memory problems for one of six sampled residents (Resident 1).</p> <p>This failure resulted in no plan of care for Resident 1's memory problems during his time at the facility.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record , the record indicated the resident was admitted to the facility on [DATE] with diagnoses including; paranoid schizophrenia, anemia, diabetes mellitus (DM-, major depressive disorder and hypertensive (high blood pressure) heart disease. The same record further indicated Resident 1 was self- responsible.</p> <p>During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 8/19/24 indicated Resident 1's cognitive (relating to mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired and had medically complex conditions. The MDS further indicated Resident 1 required set up or clean-up assistance to supervision or touching assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), toilet transfers and walking, and was independent with bed mobility.</p> <p>During a review of Resident 1's Baseline Care Plan dated 11/14/24 indicated the resident had history of memory problems and noncompliance.</p> <p>During an interview on 3/14/25 at 2:05 pm with LVN 2, LVN 2 stated if the resident had memory problems on admission there should have been a care plan developed for that.</p> <p>During a review of the facility's policy and procedures (P&P) titled Care Plans, Comprehensive Person-Centered reviewed 1/25/25, the P&P indicates A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</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 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252</p> <p>Based on interview and record review, the facility failed to ensure the attending physicians came in to visit the resident as outlined in the regulation for one of five sampled residents (Resident 1).</p> <p>This failure had the potential to effect the residents plan of care and delivery of services.</p> <p>Cross reference with F622</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record , the record indicated the resident was admitted to the facility on [DATE] with diagnoses including; paranoid schizophrenia, anemia, diabetes mellitus (DM-, major depressive disorder and hypertensive (high blood pressure) heart disease. The same record further indicated Resident 1 was self- responsible.</p> <p>During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 8/19/24 indicated Resident 1's cognitive (relating to mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired and had medically complex conditions. The MDS further indicated Resident 1 required set up or clean-up assistance to supervision or touching assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), toilet transfers and walking, and was independent with bed mobility.</p> <p>During a telephone interview with Medical Doctor (MD) 1 on 3/13/25 at 1:14 pm, MD 1 the facility was not one of his (that he sees residents at).</p> <p>During an interview with concurrent record review with Medical Records Director (MRD) on 3/13/25 at 3:00 pm Resident 1's physician's progress notes for his entire stay at the facility (11/13/23-9/11/24) were reviewed. The MRD verified there were no physician notes in the medical record after 2/8/24 and stated the physician should have made visits after that but he didn't (per the record review).</p> <p>During a review of the facility's P&P titled Physician's Visits reviewed 1/25/25 indicated The Attending Physician must make visits in accordance with applicable state and federal regulations. 1. The Attending Physician will visit residents in a timely fashion, consistent with applicable state and federal requirements . The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter.</p>		