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	12/11/2025

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the safety of one of the three residents (Resident 1) by failing to: 1. Complete the Wandering Risk and Elopement (a patient, often cognitively impaired, leaves a healthcare facility or safe area unsupervised and unnoticed, posing serious risks of injury or death) Screening Assessment on 9/26/2025 (initial admission) on 10/20/2025.2. Update Wandering and Elopement Risk Assessment as Resident one is known to have observed displaying exit seeking behavior and trying to leave the facility on 10/11/2025 and 11/4/2025.3. Develop a comprehensive care plan for elopement to prevent injuries. 4. Ensure Licensed Vocational Nurses (LVN) 1 and LVN 2, immediately intervened and continuously monitored Resident 1 who was gradually experiencing aggressive behavior by continuously kicking a window on 11/4/2025 while Resident 1 is on 1:1. As a result, On 11/4/2025 at 9:16 pm, Resident 1 was transferred to General Acute Care Hospital (GACH) 1 via 911 (the telephone number used to reach emergency medical, fire, and police services), where the resident was diagnosed with a right tibial plateau fracture (a break in the flat top surface of the shinbone [tibia] where it meets the thigh bone [femur] to form the knee joint and is often caused by high-impact trauma) and comminuted fracture of the fibular head and neck (a severe injury where the top, thinner bone on the outside of your lower leg (near the knee) has shattered into three or more pieces).Findings: A review of Resident 1's admission record indicated the facility initially admitted the resident on 9/26/2025 and readmitted on [DATE], with diagnoses that included major depressive disorder (a serious mood disorder causing persistent sadness, hopelessness, and loss of interest in enjoyable activities, lasting at least two weeks and significantly interfering with daily life, work, or relationships, differing from temporary sadness by its severity and long-lasting impact on feelings, thinking, and behavior), dementia (is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and hypertension (HTN-high blood pressure). A review of Resident 1's Order Summary dated 9/26/2025 indicated, may have psychiatric eval (evaluation) and follow-up treatment as indicated. A review of Resident 1's care plan dated 9/26/2025 with a focus on, The resident is Not an elopement risk/wanderer. The same care plan indicated a goal of, the resident's safety will be maintained through the review. A review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR, a communication tool used by healthcare workers) dated 10/11/2025 at 3:05 pm, indicated, The Resident 1 had two episodes of exit seeking and trying to leave the facility. Resident 1 was redirected multiple times. Explained to resident the risk of leaving facility without doctors' orders and that it is not safe for her to just leave. Resident expressed that she wants to go home. Resident was redirected back to her room. IDT [Interdisciplinary Team - is a coordinated group of various healthcare professionals (nurses, doctors, therapists, social workers, dietitians, activities staff, etc.) who work together with the resident and family to create and manage a personalized, holistic care plan, ensuring all medical, social, and functional needs are met for optimal recovery and well-being] was notified. MD [Medical Doctor] was notified. A review of Resident 1's SBAR dated 10/11/2025 at 8:45 pm, indicated, Resident was noted by morning shift with change of behavior attempting to get-out of fire door causing alarm to be activated. In evening shift, she [Resident 1] was noted with physical aggressiveness / combativeness during care. She [Resident 1] was very delusional [having a strong, false belief that isn't based in reality and persists even when presented with clear evidence against it, often stemming from mental health conditions] verbalizing she is Jehova, claiming she is GOD & calling staff devils. Her Physical Aggressiveness poses danger to self & to others. The NP was notified and ordered Haldol 5 mg (milligrams- unit of measurement and Benadryl 50 mg. A review of Resident 1's physician order dated 10/12/2025, indicated Resident 1 to, transfer to acute hospital [GACH 2] on 5150 [California law code that allows a qualified officer or clinician to involuntarily detain someone on a 72-hour psychiatric hold] for evaluation and management of delusion of grandeur (false, unshakable beliefs that one possesses exceptional abilities, wealth, fame, power, or a special identity [like being a deity or historical figure] that she is Jehovah [God saying she is god leading to physical aggressiveness posing danger to self and others). A review of Resident 1's physician orders for readmission dated 10/20/25, indicated that Resident 1 was readmitted to the facility on [DATE]. A review of Resident 1 document titled, Wandering Risk and Elopement Screening Assessment, dated 10/20/2025, with columns to indicate wandering and elopement behaviors, was left all blank and no initial of the nurse completing the assessment. The only entry is the date 10/20/2025. A review of Resident 1's Order Summary Report Active