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	02/03/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of four sampled residents' (Resident 2) was free from abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) and neglect (the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress) by failing to ensure staff checked on Resident 2 every 2 hours to assist the resident with toileting as needed and to provide care on 1/9/2026 on the 11PM to 7AM shift on 1/9/2026 on the 11 PM to 7 AM shift. This failure resulted in Resident 2 not receiving ADL care including incontinent care for 7 hours and 30 minutes from 1/9/2026 at 11 PM to 1/10/2026 at 5 AM when licensed vocational nurse (LVN) 2 found Resident 2 on the floor, sitting in feces (stool) placing Resident 2 at increased risk to suffer mental anguish or emotional distress. Findings: Cross Reference F689 During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (brain dysfunction caused by diseases or toxins in the body), incontinence (lack of control over urination or defecation), impaired mobility, and osteoarthritis (OA- is the most common form of arthritis, a degenerative joint disease where the protective cartilage cushioning the ends of bones wears down over time, leading to pain, stiffness, swelling, and reduced mobility as bones start rubbing together). ? During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 12/31/2025, indicated Resident 2 had intact cognition (mentality ability to think, remember and reason) for decisions of daily living, and required partial assistance for toileting, upper and lower body dressing, toilet transfer and walk 10 feet. The MDS indicated Resident 2 required supervision for eating, oral hygiene, shower/bathe self, putting on taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, and sit to stand. The MDS indicated Resident 2 used a wheelchair for mobility. During an observation on 2/3/2026 at 11:48 AM in Resident 2's room, Resident 2 was out of the room, no floor mats, no padded bed rails were placed in the room. Resident 2 was in dining room waiting for her lunch tray and when prompted questions she did not respond. Per Care Plan, Resident 2 has communication deficits related to previous stroke (disruption of blood flow to the brain due to problematic vessels that cause lack of blood supply and oxygen to the brain). During an interview on 2/3/2026 at 12 PM with Certified Nursing Assistant (CNA 1), CNA1 stated that on 1/9/2026 on the 11 PM to 7AM shift, he was not assigned Resident 2 and that a the facility's CNA nursing assignment sheet dated (typed) 1/9/2026 for the 11 Pm to 7 AM shift, did not reflect that anyone/staff was assigned to care for Resident 2. CNA1 stated that on 1/10/2026 at around 7 AM, he reported to the Director of Staff Development (DSD) the Resident 2 was on the floor and that no CNA was assigned to the resident on 1/9/2026 during the 11 Pm to 7 AM shift. CNA1 stated that on 1/10/2026 at 5 AM, the Registered Nurse (RN) Supervisor (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	instructed him to go and assist Resident 2. CNA1 stated that he was attending to his assigned residents and that on 1/10/2026 at around 6:20 AM he went to assist Resident 2. CNA1 stated that he found Resident 2?sitting on the floor and was sitting in feces (stool) and had some feces on her body. CNA1 stated that CNA3 helped him clean Resident 2. CNA1 stated that both him and CNA3 attempted to transfer the resident back in bed but were unable because the resident was heavy and could not assist them with the transfer. CNA1 stated he asked for help from the RN supervisor and LVN2, however, the RN supervisor stated he was getting off his shift., On 2/4/2026 at 10:04 AM, the RN Supervisor was contacted and voice mail left, however, no answer and no call back was received from the RN Supervisor. During an interview on 2/3/2026 at 12:52 PM with the Director of Nursing (DON), the DON stated no licensed nurse informed her aware that Resident 2 was found on the floor on 1/10/2026 and therefore the facility had failed to identify the root cause of Resident 2 being found on the floor, and also that an investigation and the root cause analysis needed to be conducted. The DON stated that failure to report the Resident 2 being found on the floor placed Resident 2 at increased risk for injury, delayed care, and compromised safety. ? During a telephone interview on 2/3/2026 at 1:30 PM with CNA1, CNA1 stated that on 1/10/2026 at 6:20 AM, the RN supervisor asked him to help clean Resident 2. CNA1 stated he was not assigned Resident 2. CNA1 stated upon entering Resident 2's room, he noticed that Resident 2 was on the floor covered in feces. CNA1 stated he asked Resident 2 what happen but Resident 2 did not say anything and kept looking at him. CNA1 stated that he then called for help and CNA3 came in to help clean Resident2. CNA1 stated that both him and CNA3 could not get Resident 2 off the floor because Resident 2 was too heavy for them to lift her and that Resident 2 was not able to assist them to get up. CNA1 stated that he then asked the Registered Nurse (RN) Supervisor to help, but the RN supervisor told CNA1 that it was almost off his (RN Supervisor) shift and provided zero assistance. CNA1 stated that Licensed Vocational Nurse (LVN) 1 is the one who, figured out that a nursing assistant had not been assigned to, Resident 2. CNA1 stated that he and CNA3 provided incontinent care to Resident 2 while the resident was on the floor. CNA1 stated that he reported to the RN supervisor that him and CNA3 were getting off the shift (signing out), and that Resident 2 remained on the floor. CNA1 stated that the RN supervisor was aware that Resident 2 was on the floor and that no staff was assigned to the Resident 2 on 1/9/2026 on the 11 PM to 7AM shift and created/developed a stop and watch form to continue to monitor the situation for Resident 2. CNA1 stated he took a picture of the stop and watch form and sent a picture it to DSD and the Administrator Assistant. During an interview on 2/3/2026 at 1:55 PM with Director of Staff Development (DSD), the DSD stated that no staff informed her of the CNA nursing assignment error (no CNA assigned to Resident 2) on the night of 1/9/2026 (11 PM to 7 AM shift). The DSD stated any issues that arise must be communicated immediately to DSD, DON, and Administrator to address any issues affecting residents. The DSD stated failure of staff to report that Resident 2 was found on the floor to leadership and failure to initiate an assessment for change in condition constituted failure to follow facility abuse and neglect reporting policy and procedures. ? During an interview on 2/4/2026 at 10:19 AM with Licensed Vocational Nurse 2 (LVN2), LVN2 stated that on 1/10/2026 at approximately 5 AM she was doing rounds on the residents and noted that Resident 2 was in her room sitting on the floor and immediately informed the RN supervisor of the incident regarding Resident 2. LVN2 stated Resident 2 remained on the floor because she, CNA1 and CNA3 were unable to lift the resident off the floor and transfer Resident 2 back to bed. LVN2 stated that it was not until 7 AM when the morning shift (7AM-3PM) came in and assisted to lift and transfer Resident 2 back to bed. LVN2 stated Resident 2 is heavy and sometimes requires three staff members to list/transfer. LVN2 stated that CNA1 is usually assigned to care for (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2, however on 1/9/2026 night, Resident 2 was not assigned a CNA on the CNA nursing assignment sheet. LVN2 stated whenever issues arise with the staff schedule/assignment, the licensed nurses are supposed to notify DSD of any situation that requires immediate attention. LVN2 stated she did not call/notify the DSD that Resident 2 was on the floor and was not assigned a CNA because she had already notified the RN Supervisor. ? During a record review of the facility policy and procedures (P&P) titled Abuse Prevention and Reporting dated 1/20/2026, indicated the facility promptly and thoroughly investigates reports of resident neglect or injuries of an unknown source. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress. Abuse includes the deprivation by any individual, including caretaker, of goods and services necessary to attain or maintain physical, mental, and psychosocial well-being. During a record review of the facility P&P titled Abuse Prevention/Prohibition with a stamp date of 1/20/2026, indicated that, The facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation and/or mistreatment, and develops Facility policies, procedures, training programs and systems in order to promote an environment free from abuse and mistreatment. The Administrator as Abuse Prevention Coordinator (APC) is responsible for the coordination and implementation of the facility's abuse prevention policies and training. Abuse is defined as the willful inflictions of injury, involuntary seclusions, physical, or chemical restraint not required to treat the residents' symptoms, intimidation or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including caretaker, of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being. 7. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the Low Air Loss mattress (LAL- a bed that alternates pressure to help heal and prevent pressure injuries) was set at the correct pressure for one of four sampled residents (Resident 1) according to the manufacturer's guide titled Dynarex LAL mattress manual. Resident 1's weight was 106 pounds (lbs-unit of weight measurement) and the LAL mattress was set for someone who weighed 350 lbs on 2/3/2026. This failure placed Resident 1 at increased risk for skin breakdown and compromised dignity. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of complete paraplegia (a total loss of voluntary movement and sensation in the lower half of the body, legs, feet, toes, due to severe spinal cord damage, completely blocking nerve signals from the brain below the injury level, often affecting bladder and bowel control too, with arm function remaining intact). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 1/7/2026, indicated Resident 1 had intact cognition (the mental ability to think, remember and reason)? for decisions of daily living. The MDS indicated Resident 2 was ?dependent on staff for lower body dressing, toileting, putting on taking off footwear, showering, toilet transfer, chair to bed to chair transfer. The MDS indicated Resident 1 required?maximal assistance for upper body dressing, personal hygiene, and required partial assistance for oral and lying to sitting on side of bed. ?The MDS indicated Resident 1 required supervision for eating, sit to lying, and was independent to roll left and right. During a record review of Resident 1's Order Summary, dated 3/31/2025, the Order Summary indicated to monitor placement and functioning of Low Air Loss Mattress for skin management every shift. During a record review of Resident 1's Care Plan (CP-a personalized document that outlines a resident's needs, goals, and the specific services required to achieve them, ensuring consistent and holistic care) with a focus on The resident has potential/impairment to skin integrity r/t (related to) fragile skin . On LAL mattress, initiated on 3/31/2025, indicated the CP goal is that the resident will maintain or develop clean and intact skin by the review date. The CP interventions indicated, LAL mattress for skin impairment prevention as ordered. LN (licensed nurse/s) to monitor placement and functioning every shift. During a concurrent observation and interview on 2/3/2026 at 12:04 PM with Licensed Vocational Nurse (LVN) 1, in Resident 1's room, the LVN1 walked into Resident 1's room to answer the call light. LVN1 asked if resident needed something, as the alarm was going off on Resident 1's bed. The surveyor asked LVN1 if she heard the alarm going off in the room and the LVN1 stated she would check to see what it was. The LVN1 inspected Resident 1's bed and stated the LAL mattress Resident 1 was laying on was set to the incorrect setting at 350 lbs, and the indicator on the machine was flashing red for low pressure. The LVN1 stated the LAL mattress should be set to 106 lbs which is Resident 1's current weight. The LVN1 stated it was the responsibility of the treatment nurse to verify correct settings during their rounds. LVN1 stated not setting LAL mattress to correct setting could worsen skin issues for residents. During an interview on 2/3/2026 at 12:52 PM with the Director of Nursing (DON), the DON stated that an incorrectly set LAL mattress can negatively impact a resident's skin management and overall pressure injury prevention plan. The DON stated she was aware of the incident with Resident 1 being left soiled for three days and it was unacceptable for staff to leave him soiled for that long despite Resident 1's history of refusal for ADLs. During a review of the facility policy and procedures (P&P) titled Activities of Daily Living (ADLs), Supporting, dated 1/20/2026, indicated Residents will be provided with care and services to maintain or improve their ability to carry out ADLs. Appropriate services will be provided to residents who are (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unable to carry out ADLs independently including hygiene and toileting to prevent or minimize functional decline. Interventions to improve or minimize a resident's functional abilities will be in accordance with resident's assessed needs, preferences, stated goals, and recognized standards of practice. During a record review of manufacturer's guide titled Dynarex LAL mattress manual provided by the facility, the manufacturer's guide manual indicated, to increase or decrease airflow for a softer or firmer mattress setting the numbers denote suggested setting based on patient weight. LOW PRESSURE light will illuminate and alarm sounds when the pressure is below the preset level.

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F 0689 Level of Harm - Minimal harm or potential for 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** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents' (Resident 2) did not suffer an unwitnessed fall on 1/9/2026 on the 11 PM to 7 AM shift as evidenced by failing to: Ensure that staff checked on Resident 2 every 2 hours to assist the resident with toileting as needed and to provide care on 1/9/2026 on the 11Pm to 7AM shift as stated in Resident 2's Care Plan (CP-a personalized document that outlines a resident's needs, goals, and the specific services required to achieve them, ensuring consistent and holistic care) titled Resident is at Risk for falls . initiated on 3/6/2025. 2Place floor mats on the floor for safety on 2/3/2026 as ordered by physician. This failure resulted in Resident 2 being found in her room on the floor (unknown length of time) sitting in feces on 1/10/2026 at approximately 5 AM. Resident 2 remained on the floor on 1/10/2026 until 7 AM when the oncoming shift staff lifted Resident 2 off the floor. This failure resulted in. Resident 2 being found in her room on the floor (unknown length of time) sitting in feces on 1/10/2026 at approximately 5 AM. Resident 2 remained on the floor on 1/10/2026 until 7 AM when the oncoming shift staff lifted Resident 2 off the floor. Findings: Cross Reference F600 and F690 During a record review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of incontinence (lack of control over urination or defecation), impaired mobility, and osteoarthritis (OA- is?the most common form of arthritis, a degenerative joint disease where the protective cartilage cushioning the ends of bones wears down over time, leading to pain, stiffness, swelling, and reduced mobility as bones start rubbing together). During a record review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 12/31/2025, indicated Resident 2 had intact cognition (ability to think, remember and reason) for decisions of daily living, and required partial assistance for toileting, upper and lower body dressing, toilet transfer and walk 10 feet. The MDS indicated Resident 2 required supervision for eating, oral hygiene, shower/bathe self, putting on taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, and sit to stand. During a record review of Resident 2's CP with a focus on The Resident is at Risk for falls r/t (related to . incontinence. and unaware of safety needs, initiated on 3/6/2025, indicated that Resident 2 will be free of falls. The CP interventions indicated to place floor mats for safety, keep bed in the lowest position at all times, monitor and reassess as needed, and anticipate and meet the resident's needs. The resident needs prompt response to all requests for assistance . Follow facility fall protocol. The resident needs a safe environment. During a record review of Resident 2's CP with a focus on The resident has bowel incontinence., initiated on 3/6/2025, the CP interventions indicated to check the resident every two hours and assist with toileting as needed and to provide pericare after each incontinent episode . During a record review of Resident 2's CP with a focus on Risk for falls, initiated on 3/18/2025, the CP indicated that Resident 2 will be free of falls. The CP interventions indicated to evaluate the resident for fall risk on admission and PRN (as necessary). During a record review of Resident 2's CP, dated 1/12/2026, indicated Resident 2 has an ADL self-care deficit and requires skin inspection, and assistance by staff for toileting. The CP indicated Resident 2 was at risk for falls, and in order to promote safety, floor mats will be placed as indicated. The CP indicated Resident 2 has impaired cognitive function and thought process related to psychotropic (Drugs/medications that affect a person's mental state) use and interventions required staff to cue, reorient and supervise as needed. During a record review of Resident 2's Fall Risk Evaluation, dated 1/6/2026, indicated Resident 2 requires use of assistive devices, takes 1-2 medications that places Resident 2 at risk for falls, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and has a high fall risk. During a record review of the facility typed CNA Assignment Sheet dated 1/10/2026 at 11PM to 7AM, indicated the date of 1/10/2026 was handwritten/modified to reflect a date of 1/9/2026. During a record review of Resident 2's Order Summary dated 1/12/2026 , indicated, place floor mats for safety. During an observation on 2/3/2026 at 11:58 AM in Resident 2's room, Resident 2's room did not have floor mats in the room as ordered by physician. Resident 2 was not in the room. During an interview on 2/3/2026 at 12 PM with Certified Nursing Assistant (CNA) 1, CNA1 stated that on 1/9/2026 during the 11PM to 7 AM shift, he was not assigned Resident 2. CNA1 stated that on 1/10/2026 at 6:20AM, the Registered Nurse (RN) Supervisor asked him to clean up/provide care to Resident 2. CNA1 stated that he immediately reviewed the CNA nursing assignment for the residents dated 1/9/2026 and 1/10/2026 and noted that no CNA was assigned to Resident 2. CNA1 stated himself and CNA3 cleaned Resident 2 on 1/10/2026 at approximately 6:20 AM. CNA1 stated that Resident 2? was sitting in her feces. CNA1 stated that?himself and CNA3 were unable to lift Resident 2 off the floor and informed the RN Supervisor and Licensed Vocational Nurse (LVN) 2. CNA1 stated that the RN supervisor said that he (RN supervisor) was getting off his shift. CNA1 stated that he informed the RN supervisor that it was time for him and CNA 3 to sign off. CNA 1 stated that both him and CNA3 signed out at 7 AM leaving Resident 2 on the floor. During an interview on 2/3/2026 at 12:52 PM with the Director of Nursing (DON), the DON stated that no licensed staff informed her that Resident 2 was found on the floor on 1/10/2026, therefore the facility failed to identify the root cause why Resident 2 was found on the floor, and an investigation needed to be conducted. The DON stated that failure to report the incident placed Resident 2 at risk for injury, delayed care, and compromised safety. During an interview on 2/3/2026 at 1:55 PM with the Director of Staff Development (DSD), the DSD stated that no one informed her of the CNA nursing assignment error (No CNA assigned to Resident 2) on the night of 1/9/2026. The DSD stated any issues that arise must be communicated immediately to leadership to address any issues affecting residents. The DSD stated failure of staff to report the incident to leadership and failure to initiate an assessment for change in condition constituted failure to follow facility abuse and neglect reporting policies. On 2/4/2026 at 10:04 AM, RN Supervisor was contacted by phone. A voicemail was left; however, the RN supervisor did not call back. During an interview on 2/4/2026 at 10:19 AM with the LVN2 stated that on 1/10/2026 at approximately 5 AM she was the charge nurse on the shift and was the first time on her shift (1/9/2026 from 11PM to 7AM [1/10/2026] that she made rounds of the residents rooms and noted Resident 2 to be sitting on the floor in the room. LVN2 stated CNA1 is usually assigned to care for Resident 2, however on that particular night 1/9/2026, the CNA nursing assignment sheet had failed to assign any CNAs to Resident 2. LVN2 stated she reported to the RN supervisor and stated no one responded to help her lift Resident 2 off the floor until 7 AM when the morning shift (7AM-3PM) reported to work. LVN2 stated at least two staff are required to lift up Resident 2 because Resident 2 weighs 224 pounds (lbs.-unit of weight) and sometimes three staff are required. LVN2 stated whenever issues arise with the schedule they are supposed to notify DSD to make them aware of any situation that requires immediate attention. LVN2 stated she did not call the DSD at that time because she had notified the RN Supervisor. During a review of the facility policy and procedures (P&P) titled Falls, Fall Risk Managing dated 1/20/2026, indicated, a fall is defined as unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. Resident conditions that may contribute to the risk of falls include medication side effects, functional impairments, and incontinence. During a review of the facility P&P titled Accidents and Incidents-Investigating and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reporting dated 1/20/2026, indicated, the Nurse Supervisor, Charge Nurse or department director shall initiate and document investigation of the accident or incident on the Report of Incident/ Accident form within 24 hours of the incident or accident to include: a.????????? The date and time the accident or incident took place; b.????????? The nature of the injury/illness (e.g., bruise, fall, nausea, etc.); c.?????????? The circumstances surrounding the accident or incident; d.????????? Where the accident or incident took place; e.?????????? The name(s) of witnesses and their accounts of the accident or incident; f.??????????? The injured person's account of the accident or incident; g.?????????? The time the injured person's Attending Physician was notified, as well as the time the physician responded and his or her instructions; h.????????? The date/time the injured person's family was notified and by whom; i.??????????? The condition of the injured person, including his/her vital signs; j.??????????? The disposition of the injured (i.e., transferred to hospital, put to bed, sent home, returned to work, etc.); k.?????????? Any corrective action taken; l. ?????????? Follow up information m.???????? Signature and title of the person completing the report.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide incontinent (lack of control over urination or defecation) care and appropriate pressure injury (an injury that breaks down the skin and underlying tissue when an area of skin is placed under pressure) prevention interventions for one of four residents (Resident 1) as evidenced by Resident 1 wearing the same incontinent (the involuntary loss of bladder control (urine) or bowel control (feces/stool) brief (designed for managing moderate to heavy bladder or bowel incontinence) that Certified Nursing Assistant (CNA) 1 applied on the resident on 1/6/2026 at 5:30 AM through 1/10/2026 at 1AM (approximately three days). CNA1 wrote his initials, time, and date when he applied the incontinent brief on Resident 1. This failure placed Resident 1 at risk for skin breakdown and compromised dignity. Findings; During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of complete paraplegia (a total loss of voluntary movement and sensation in the lower half of the body, legs, feet, toes, due to severe spinal cord damage, completely blocking nerve signals from the brain below the injury level, often affecting bladder and bowel control too, with arm function remaining intact). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 1/7/2026, indicated Resident 1 had intact cognition (ability to think, remember and reason)? for decisions of daily living. The MDS indicated Resident 1 was ?dependent on staff (Helper does ALL of the effort) for lower body dressing, toileting, putting on taking off footwear, showering, toilet transfer, chair to bed to chair transfer. The MDS indicated Resident 1 required? maximal assistance (Helper does MORE THAN HALF the effort) for upper body dressing and personal hygiene, and required partial assistance (Helper does LESS THAN HALF the effort) for oral hygiene and lying to sitting on side of bed. ?The MDS indicated Resident 1 required supervision for eating, sit to lying, and was independent to roll left and right. During a record review of Resident 1's Care Plan (CP -a personalized document that outlines a resident's needs, goals, and the specific services required to achieve them, ensuring consistent and holistic care) with a focus on The resident has bowel incontinence., initiated on 3/31/2025, indicated change disposable briefs every 2 hours per shift and as needed, clean peri-area (peri-anal- area between the genitals and the anus) with each incontinence episode, wash, rinse and dry perineum. Change clothing as needed after incontinent episodes.? During an interview on 2/3/2026 at 12:06 PM with Certified Nursing Assistant (CNA) 1, CNA1 stated Resident 1 is dependent on staff for toileting and activities of daily living (ADLs). CNA1 stated that on 1/6/2026 he was assigned to care for Resident 1 who was dependent on staff for toileting and activities of daily living (ADLs) and that he changed/provided incontinent care to Resident 1. CNA1 stated that on 1/6/2026, he applied a clean incontinent brief on Resident 1 and dated the time he changed the incontinent brief because he was concerned that staff do not provide incontinent care/change for Resident 1 as required. CNA1 stated he was off duty for the next few days, and when he returned to work on 1/10/2026, he noticed that Resident 1 was still wearing the same incontinent brief dated 1/6/2026 and reported this to the Director of Nursing (DON). During an interview on 2/3/2026 at 12:52 PM with the Director of Nursing (DON), the DON stated she was aware of the incident when Resident 1 was left soiled (left in urine/stool) and wearing the same incontinent brief for three days. The DON stated, it was unacceptable for staff to leave him soiled for that long despite [Resident 1's] history of refusal for ADLs. The DON stated failure to provide incontinent care placed Resident 1 at increased risk for skin breakdown and affected his dignity as a human being. During an interview on 2/3/2026 at 1:55 PM with the Director of (continued on next page)

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	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miracle Mile Healthcare Center, LLC	1020 South Fairfax Ave Los Angeles, CA 90019

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff Development (DSD), the DSD stated that CNA1 notified her of the incident when Resident 1 was left soiled for three days and staff should make all efforts to prevent this from ever happening to any resident. The DSD stated staff are supposed to document resident refusal for ADLs, escalate the issue to charge nurse, nurse supervisor, DSD, or DON, investigate the reason for the refusal and assign preferred staff to residents who have preferences for care. During a review of the facility policy and procedures (P&P) titled Activities of Daily Living (ADLs), Supporting, dated 1/20/2026, indicated Residents will be provided with care and services to maintain or improve their ability to carry out ADLs. Appropriate services will be provided to residents who are unable to carry out ADLs independently including hygiene and toileting to prevent or minimize functional decline. Interventions to improve or minimize a resident's functional abilities will be in accordance with resident's assessed needs, preferences, stated goals, and recognized standards of practice. During a review of the facility policy and procedures (P&P) titled Fecal Incontinence, dated 1/20/2026, indicated the purpose of this procedure is to provide guidelines that will aid in preventing the resident's exposure to feces. Review the resident's care plan to assess for any special needs of the resident. Residents must be cleaned after each episode of incontinence. Notify the supervisor if the resident refuses the care.