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	04/08/2026

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 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 the residents' environment remained free from accidents and hazards for ambulatory cognitively impaired residents, by failing to provide adequate supervision and monitoring for two out of three sampled residents, (Resident 1 and Resident 2) according to the facility's policy and procedures (P&P) titled, Safety and Supervision of residents with a review date of 1/20/2026. This deficient practice resulted in an unexpected and unintentional resident altercation that had the potential to result in significant physical injury and burns. Findings: A review of Resident 1's admission record indicated the Resident was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included depression (mood disorder characterized by persistent sadness, low mood, and a loss of interest in activities), circadian rhythm sleep disorder (conditions where a person's internal biological clock is out of sync with their environment, causing severe sleep disruptions), psychoactive substance abuse (abuse of chemical compound-legal or illicit-that alters brain function, affecting perception, awareness, mood, consciousness, or behavior), muscle wasting and atrophy (thinning, or loss of muscle tissue, resulting in decreased muscle mass, strength, and mobility) and glaucoma (progressive optic neuropathy (damage to the optic nerve) that leads to irreversible vision loss or blindness.). A review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated, 3/31/2026, indicated Resident 1's cognitive (mental ability to make decisions for daily living) was intact, Resident 1 required setup or clean-up assistance with eating, partial moderate assistance with putting on/taking off footwear, Resident 1 required substantial/ maximum assistance with oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing and personal hygiene, Resident 1 was non-ambulatory and wheelchair dependent for mobility. A review of Resident 2's admission record indicated the Resident was originally admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included metabolic encephalopathy (brain dysfunction caused by chemical imbalances, systemic illness, or organ failure), epilepsy (recurrent, unprovoked burst of electrical activity in the brain that causes temporary changes in movement, behavior, sensation, or awareness), heart failure (a condition in which the heart muscle cannot pump blood efficiently enough to meet the body's metabolic needs), type 2 diabetes mellitus (high levels of sugar in the blood), bipolar disorder (mental health condition characterized by extreme, often debilitating shifts in mood, energy, and activity levels) and Dementia with agitation (a behavioral syndrome characterized by persistent, excessive motor activity, verbal aggression, or physical aggression, causing significant emotional distress). A review of Resident 2's MDS, dated , 3/24/2026 indicated Resident 2's cognitive (mental ability to make decisions for daily living) was moderately impaired, Resident 2 was required setup or clean -up assistance with eating, supervision or touching assistance with oral hygiene and upper body dressing, partial moderate assistance with toileting hygiene, shower/bathes, lower body dressing and, putting on/taking off footwear. Resident 2 once standing, required supervision or touching assistance with walking up to 50 feet with two turns. During an interview on 4/7/2026 at 12:24 pm, Resident 1 stated that on 3/23/2026 at approximately 8:00 pm, he (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
	555139	A. Building B. Wing	04/08/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Resident 1) was by the Coffee cart that was parked by the elevator waiting to pour some coffee for himself. Resident 1 stated he became impatient because Resident 2 who was ahead of him (Resident 1) at the coffee cart was taking too long to pour his (Resident 2's) own coffee. Resident 1 decided to wheel himself to the smoking area without getting coffee. Resident 1 stated, shortly thereafter (about 5-minutes later) 2 to 3 nurses (unable to recall names) walked Resident 2 towards the smoking area where he (Resident 1) was waiting for the smoking area patio to be opened so he could smoke a cigarette. Resident 1 stated, without provocation and for reasons unknown to him (Resident 1), Resident 2 threw hot coffee on Resident 1's face, Resident 1 states the nurses started laughing. Resident 1 states his eyes were burning, states he does not remember any nurse offering him first aid and/or assisting him with cleaning his face. During an interview on 4/7/2026 at 1:48 pm Certified Nurse Assistant (CNA2) stated Resident 1 had reported to her (CNA2) that Resident 2 had poured hot coffee on his (Resident 1's) face, CNA2 stated Resident 1 said his eyes were bothering him and he (Resident 1) is unable to see well out of 1 of his eyes (unable to state which eye is affected). During a concurrent interview on 4/7/2026 at 3:48 pm, Registered Nurse (RN) 1 and Licensed Vocational Nurse (LVN) 1 stated they did not witness Resident 2 spill coffee on Resident 1. RN1 and LVN1 stated that on 3/23/2026 Resident 1 came to the nursing station and said that Resident 2 had spilled coffee on him (Resident 1). RN1 stated Resident 2 denied spilling coffee of Resident 1 but was holding a cup with very little coffee left in the cup, Resident 1 was observed to have coffee on his face and clothes. RN1 stated she assessed Resident 1 and called Paramedics (highly trained healthcare professional providing advanced, life-saving emergency medical care) and the Police (law enforcement). RN1 stated when paramedics and police arrived to assist Resident 1, however, Resident 1 refused to go to the hospital and did not want to talk to the police. RN1 stated Resident 2 was placed on a 5150 (an involuntary, 72-hour emergency detention of an adult deemed a danger to themselves, danger to others, or gravely disabled due to a mental health crisis) hold and transferred to a higher level of care on 3/24/2026 at 1:00 am in the morning. During an interview on 4/8/2026 at 10:58 am, the Dietary Supervisor (DS) stated the facility kitchen is closed at 8 pm., and prior to closing the kitchen, the kitchen staff usually take 2 (two) coffee carts with hot coffee containers upstairs and park the carts in-front of the nursing station. DS stated that the cart has one container have 4.7 gallon(unit of measurement) of coffee insulated container with hot coffee and the other container has 4.7-gallon hot water dispenser for tea (temperature range 175-180 degrees Fahrenheit), and condiments (tea bags, sugar, and hot chocolate packets) are placed in the cart and parked hallway Infront of the nursing station. During a telephone interview on 4/8/2026 at 11:07 am certified nursing assistant (CNA) 3 stated she did not witness Resident 2 spilling coffee on Resident 1. However, the coffee cart with hot coffee is usually parked was placed at the nursing station and the residents pour coffee by themselves. CNA3 stated Resident 2 pours his own coffee. CNA3 stated Resident 2 can be combative without provocation, yells and if re-directed he (Resident 2) will get agitated. During a follow-up interview on 4/8/2026 at 11:40 am LVN1 stated that on 3/23/2026, the coffee cart was parked by the hallway in-front of the nursing station. LVN1 stated the residents usually pour their own coffee except when they need assistance, LVN1 stated she was unsure who gave Resident 2 coffee. LVN1 stated Resident 2 is forgetful, is unable to remember his room and needs re-direction, LVN1 stated Resident 2 can get very agitated, is paranoid and will interrupt other people's conversations. LVN1 stated Resident 2 frequently ambulates in the hallways and occasionally uses a wheelchair to get around. During an interview on 4/8/2026 at 12:21pm, LVN2 stated, a confused and/or agitated resident accessing hot coffee without supervision can get scalded by the hot coffee and/or throw hot coffee on/at another resident or staff resulting in scalding, unnecessary hospitalization, pain and suffering, prolonged healing and permanent scarring. During an interview on 4/8/2026 at 12:38pm, Director of Nursing (DON) stated a confused and/or agitated Resident pouring and or drinking hot coffee unsupervised could cause severe second- degree (partial-thickness burn - damages the top layer (epidermis) of the skin and the underlying layer (dermis) of the skin) or third-degree burns (is a (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	04/08/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	severe injury destroying all layers of skin (epidermis and dermis and underlying fat, sometimes muscles and bones requiring skin grafts), resulting in immediate skin destruction, blistering, permanent scarring, and potential nerve damage on themselves and/or other residents and staff, unnecessary hospitalization and prolonged pain and suffering. A review of facility policy and procedures (P&P) titled, Safety and Supervision of Resident with a review date of 1/20/2026, indicated, Our facility strives to make the environment as free from accidents hazards as possible. For example, resident supervision may need to be increased when there are temporary hazards in the environment.