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	04/16/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the accuracy of Minimum Data Set (MDS - resident assessment tool) for one of seven sampled residents (Resident 2).This failure resulted in an inaccurate assessment for Resident 2 and had the potential to affect the delivery of care and services.During a review of Resident 2's admission Record, dated 4/16/26, indicated Resident 2 was admitted to the facility on [DATE], with a diagnoses including; bradycardia (slow heart rate), hypertensive heart disease with heart failure (occurs when chronic high blood pressure causes the heart to work harder, resulting in thickened (hypertrophied) or weakened heart muscle), cardiomyopathy (disease of the heart muscle that makes it harder for the heart to pump blood), and hemiplegia (muscle weakness on one side of the body) of the left nondominant side.During a review of Resident 2's Minimum Data Set (MDS-resident assessment tool) dated 4/1/26 indicated Resident 2 had intact cognition (ability to reason, make decisions, remember, judge).During a concurrent interview and record review on 4/16/26 at of the Resident 2's MDS dated [DATE] indicated the resident was independent for self-care, indoor mobility, stairs and functional cognition (resident's need for assistance with regular tasks, such as remembering tasks or to take medication prior to the current illness) and required setup or clean-up assistance with eating and upper body dressing, and supervision touching assistance with other activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), as well as, mobility actions of sit-to-stand, chair-to-stand, toilet transfer and walking 10 feet. The MSD nurse stated she goes to the resident's bedside to do the assessment and acknowledged the discrepancy in the assessment reviewed, which indicated the resident was independent to later indicating the resident needed assistance. The MDS states her assessment is correct and Resident 2 needs assistance further stating all residents need assistance or they wouldn't need to be here.During an interview on 4/16/26 with Licensed Vocational Nurse (LVN) 3, outside of Resident 2's room. LVN 3 stated Resident 2 is independent of all ADLs and does not need any help. He ambulates down the hall with a steady gait and does not require setup assistance with meals. He will have the certified nursing assistant (CNA) put the tray inside his room and he will do everything to eat independently further stating the resident dresses and toilets alone.During an interview with the Director of Nursing (DON) on 4/16/26 at 4:22 pm, the DON stated Resident 2 is known to be independent for ADLs an walking, she doesn't know why the MDS coded the record as him needing assistance and added she maybe she needs some training she is new.During a review of the facility's policy and procedures (P&P) titled Electronic Transmission of MDS reviewed 1/20/26 indicated, All MDS assessments (e.g., admission, annual, significant change, quarterly review, etc) and discharge and reentry records are completed and electronically encoded into our facility's MDS information system. Staff members are trained on updates/revisions to the MDS form.During a review of the facility's P&P titled Charting and Documentation reviewed 1/20/26 indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure interventions performed during a change of condition incident were documented in the medical record for one of seven sampled residents (Resident 1)This failure resulted in an incomplete medical record for Resident 1 and had the potential to affect the delivery of care and services.During a review of Resident 1's admission Record, dated 4/16/26, indicated Resident 1 was admitted to the facility on [DATE], with a diagnoses including; chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), hypertension (HTN - high blood pressure), anemia (a condition where the body does not have enough healthy red blood cells), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), and muscle weakness.During a review of Resident 1's History and Physical (H&P), dated 3/27/26, indicated the resident lacks decision making capacity.During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool) dated 3/24/26 indicated Resident 1 short- and long-term memory problems and had severely impaired daily decision making. The same MDS indicated the resident required substantial/maximal to total dependance on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and bed mobility.During a concurrent interview and record review on 4/15/26 at 3:32 pm with Licensed Vocational Nurse (LVN) 1, Resident 1's Change of Condition (COC) progress note and Facility Transfer Form dated 3/27/26 were reviewed. Neither form indicated the resident had an intervention for the low oxygen saturation (oxygen saturation (SpO2) normal level 95%-100%, indicating the percentage of hemoglobin carrying oxygen) indicated in on the COC progress note of 86%. LVN 1 verified there was no documentation in either the progress note of form for the intervention for low SpO2 level and stated the doctor was there during the incident (indicated in the record) and ordered a nonrebreather mask with oxygen (NRM - medical device used in emergency situations to deliver high concentrations of oxygen (60%-100%) to patients who are breathing on their own but experiencing severe respiratory distress or low blood oxygen levels (hypoxia)) which was placed on the resident but it was not documented.During a review of the facility's policy and procedures (P&P) titled Change in a Resident's Condition or Status reviewed 1/20/26 indicated The nurse will record in the residents medical record information relative to changes in the resident's medical/mental condition or status.During a review of the facility's P&P titled Charting and Documentation reviewed 1/20/26 indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The following information is to be documented in the resident medical record:. Treatments or services performed. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Documentation of procedures and treatments will include care-specific details, including:. How the resident tolerated the procedure/treatment.