

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  01/05/2025
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455</b></p> <p>Based on interview and record review, the facility failed to obtain informed consent (a process during which residents or caregivers are educated regarding the potential risks and benefits of medication therapy) from the resident or their responsible party (a person delegated to make medical decisions for the resident in the event they are unable to do so) prior to treatment for 2 out of 30 sampled Resident's (Resident 50 and Resident 84).</p> <p>The deficient practice of failing to obtain informed consent prior to initiating treatment with psychotropic medications (medications that affect brain activities associated with mental processes and behavior) could have prevented Resident 50 and 84 from exercising his right to decline to take psychotropic medications.</p> <p>Findings:</p> <p>1. A review of Resident 50s admission indicates Resident 50 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), gout (a form of inflammatory arthritis (joint inflammation) characterized by the deposition of uric acid crystals in the joints, leading to pain, swelling, and redness.), chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter blood properly), and type II Diabetes (condition that caused by the body inability to regulate and use sugar as a fuel).</p> <p>A review of Resident 50s history and physical (H&amp;P) dated 9/18/2024 indicated Resident 50 has the capacity to understand and make decisions.</p> <p>A review of Resident 50s A review of the Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 11/20/2024, indicated Resident 50's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired for daily decision making.</p> <p>A review of Resident 50's psychotropic drug, physical restraint or medical device informed consent indicated physician obtained consent from the resident (no resident signature), and the facility was unable to identify the signature of the nurse verifying the consent for:</p> <p>(continued on next page)</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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Mirtazapine (Medication use to treat depression) 7.5 milligrams (mg) at bed time (QHS) for depression manifested by (M/B) verbalization of feeling depressed consent is dated 9/18/2024 without signature of the physician.</p> <p>Divalproex Sodium (medication to treat bipolar disorder) DR 250 mg twice a day (BID), 125MG at QHS for bipolar disorder M/B yelling with labile mood.</p> <p>2. A review of Resident 84's medical records indicated Resident 84 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included osteo arthritis (a degenerative joint disease, in which the tissues in the joint break down over time), chronic kidney disease (disease characterized by progressive damage and loss of function in the kidney), major depressive disorder (a persistently low or depressed mood and a loss of interest in daily activities), anxiety disorder (excessive and persistent feelings of fear, worry, dread, and uneasiness that significantly impair a person's functioning or cause distress), hypertensive heart disease (heart problems that develop over time due to high blood pressure) and diabetes mellitus (abnormally high blood sugar levels).</p> <p>A review of Resident 84's H&amp;P dated 10/8/2024 indicated Resident 84 had the capacity to understand and make decisions.</p> <p>A review of Resident 84's MDS dated [DATE] indicated Resident 84's cognition was intact.</p> <p>A review of Resident 84's psychotropic drug, physical restraint or medical device informed consent indicated the physician obtained consent from the Resident (no resident signature), and the facility was unable to identify the signature of the nurse verifying the consent for:</p> <p>Sertraline (Medication use to treat depression) 50mg daily for depression manifested by (M/B) verbalization of sadness consent dated 6/18/2024.</p> <p>Trazadone (Medication use to treat depression) 50mg QHS for depression m/b inability to sleep 6hrs or more at night consent undated.</p> <p>During an interview on 1/5/2025 at 6 pm DON stated with if resident can make medical decisions consent must be signed by the resident agreeing to psychotropic medications. DON further stated the prescribing physician is also supposed to sign the consent, to ensure the order is right, doctor is also supposed to explain the risks and benefits of the medications to the Resident.</p> <p>A review of facility policy and procedure (P&amp;P) titled, psychoactive medication informed consent, dated 3/2024 indicated, Prior to the administration of any psychoactive medications an informed consent for the specific medication will be obtained by the physician and verified by the nurse Policy further states the prescriber must personally examine the resident and obtain informed written consent signed by the Resident or the Resident's representative long with the signature of the healthcare professional declaring the required material information has been provided.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46843</p> <p>Based on interview and record review, the facility failed to ensure three of 25 residents (Resident 48, Resident 97, and Resident 105) had the Advance Directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) or Advanced Directives Acknowledgement forms (a signed acknowledgment indicating the resident and/or resident representative were provided with information regarding creating an Advanced Directive) documented in the residents' active medical record.</p> <p>This deficient practice violated the residents' and/or the representatives' right to be fully informed of the option to formulate their advance directives and had the potential to cause conflict with the residents' wishes regarding health care. And had the potential for Resident 48, Resident 97, and Resident 105 to be denied the right to request or refuse medical care and treatment.</p> <p>Findings:</p> <p>a. A review of Resident 97's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including diabetes mellitus (a disease characterized by elevated levels of blood sugar), hypertension (high blood pressure), and chronic kidney disease (kidneys are gradually becoming less and less capable of removing waste from the blood of the body).</p> <p>A review of Resident 97's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 12/26/24, indicated Resident 97's cognition (a person's mental ability to think, learn, remember, use judgement, and make decisions) was intact. The MDs indicated the resident required partial to moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort needed to complete activities of daily living (ADL's-they include bathing, showering, dressing, getting in and out of bed or chair, toileting, and eating).</p> <p>During review of Resident 97's medical record on 1/5/25 at 10:48 am, no advanced directive was noted in the resident's electronic health record or physical chart.</p> <p>During an interview on 1/5/25 at 10:46 am Registered Nurse Supervisor (RNS) 1 confirmed by stating there was no advanced directive in the chart for Resident 97. RNS 1 stated it was important to have an advanced directive in the resident's chart to understand the end of life wishes for the resident in case of emergency. RNS 1 stated it was important to have an advanced directive in the medical record because it would prevent the resident from receiving unwanted treatment and would allow the facility to respect and honor the resident's last wishes.</p> <p>During an interview on 1/5/25 at 4:23 pm, the Director of Nursing (DON) stated all advanced directives or the declinations, stating the end of life wishes of the resident or the resident representatives had to be immediately accessible in the residents' charts. The DON stated if the advanced directive information was not available, the residents could be subjected to unnecessary medical treatment, or medical treatment against the resident's wishes.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facilities policy titled Advance Directives dated, revised 12/2016 indicated Policy Statement: Advance directives will be respected in accordance with state law and facility policy. Policy Interpretation and Implementation. 7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. 21. The Nurse Supervisor will be required to inform emergency medical personnel of a resident's advance directive regarding treatment options and provide such personnel with a copy of such directive when transfer from the facility via ambulance or other means is made.</p> <p>45455</p> <p>b. A review of Resident 48's Admission Record, indicated the facility originally admitted Resident 48 on 4/25/2024, with diagnoses that included, Hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side (weakness or paralysis on the left side of their body due to a stroke that damaged the right side of their brain), muscle wasting and atrophy (the loss or thinning of muscle tissue), hyperlipidemia (a medical condition characterized by abnormally high levels of lipids (fats) in the blood), hypertension (High blood pressure), and morbid obesity (A serious health condition that results from an abnormally high body mass that is diagnosed by having a body mass index (BMI) greater than 40).</p> <p>A review of Resident 48's history and physical (H&amp;P) dated 4/25/2024 indicated Resident 48 could make needs known but could not make medical decisions and was unable to complete an advance directive.</p> <p>A review of Resident 48's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 10/31/2024, indicated Resident 48's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact for daily decision making.</p> <p>c. A review of Resident 105's admission record, indicated facility originally admitted Resident 105 to the facility on [DATE] with a re-admitted [DATE] with diagnoses that included, metabolic encephalopathy (a brain disorder that occurs when there's an imbalance of chemicals in the blood ), type 2 diabetes mellitus with foot ulcer (a full-thickness skin sore that develops on the foot of a person with type 1 or type 2 diabetes ) muscle wasting and atrophy (loss of muscle mass and strength), hypertension (High blood pressure), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), mild protein-calorie malnutrition (a condition in which a lack of sufficient energy or protein to meet the body's metabolic demands, as a result of either an inadequate dietary intake of protein, intake of poor quality dietary protein, increased demands due to disease, or increased nutrient losses) and anemia (a condition characterized by a low level of red blood cells (erythrocytes) or hemoglobin in the blood).</p> <p>A review of Resident 105's H&amp;P indicated Resident 105 did not have the capacity to understand and make decisions and was unable to complete an advance directive.</p> <p>A review of Resident 105s Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 12/10/2024, indicated Resident 105's cognition was moderately impaired for daily decision making.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 1/4/2025 at 11:59 AM licensed vocational nurse 4 (LVN 4) stated the advance directive in Resident 48's chart was not signed by Resident 48's representative and/or power of attorney (POA). LVN stated there was no Advance Directive (A notice of health care wishes in advance) in Resident 105's clinical record. LVN 4 was unable to provide evidence indicating Resident 48 or Resident 105's Representatives and/or POA's were asked to provide or given information regarding an Advance Directive.</p> <p>During an interview on 1/5/2024 at 6:00 PM, the Director of Nursing (DON) stated facility staff were required to complete an advance directive within 72 hours of a Residents admission, to know what the Residents wishes in the event the residents become incapacitated.</p> <p>A review of the facility's policy and procedure titled, Advance Directives dated 12/2016, indicated Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. Written information will include a description of the facility's policies to implement advance directives and applicable state law. If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directive. Information about whether the resident has executed an advance directive shall be displayed prominently in the medical record. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>46843</p> <p>Based on observation, and interview, the facility failed to ensure a comfortable, homelike environment for one out of five residents (Resident 3).</p> <p>This failure resulted in Resident 3 feeling uncomfortably cold while resting in her bed without bed covering such as, a top sheet and blankets, in addition resident had no pillowcase for her pillow.</p> <p>Cross Reference: F908</p> <p>Findings:</p> <p>A review of Resident 3's admission record indicated the facility initially admitted Resident 3 on 8/8/2024 with diagnoses that included hypertension (high blood pressure), diabetes mellitus (a disease characterized by elevated levels of blood sugar), chronic obstructive pulmonary disease (COPD) (a lung disease that damages the lungs and makes breathing difficult).</p> <p>A review of Resident 3's minimum data set (MDS- a standardized assessment and care screening tool) dated 11/13/2024, indicated Resident 3 was cognitively intact (able to make decisions concerning care, alert to situation and oriented to place and time). The MDS indicated the resident required supervision and touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completed activities of daily living (shower, toileting hygiene, upper and lower body dressing).</p> <p>During observation in Resident 3's room on 01/02/25 at 7:02 pm, Resident 3 was observed laying on the bed with no blanket or linen, aside from the fitted sheet that was on the bed.</p> <p>During an interview on 01/02/25 at 7:02 pm, Resident 3 stated the certified nursing assistant (CAN) on day shift removed the resident's linen to change the linen for the day, however there was no clean linen available, so the CNA took the used linen and did not return. Resident 3 did not remember the time the CNA took the linen; however, stated the CNA took the linen in the morning and the resident had not had any linen on the bed since early that morning.</p> <p>During an interview on 01/02/25 at 7:28 pm, CNA 1 Stated, Linen was changed in the morning, and as needed. CNA 1 stated residents should always have a top sheet and a blanket along with pillowcases. CNA 1 stated she (CNA1) was not able to replace the linen for Resident 3 because the linen had not been delivered to the floor for staff.</p> <p>During an interview on 1/5/25 at 4:23 pm, the Director of Nursing (DON) stated all residents had the right to have a homelike environment to the extent possible while living in the facility. The DON stated having a homelike environment meant the resident's beds were to be completely made with clean linen daily. The DON stated linen included a fitted sheet, cover sheet with pillowcases and a blanket. The [NAME] stated if the beds were not clean and with all the linen on the bed, then the resident would experience the discomfort of not having a homelike environment.</p> <p>(continued on next page)</p>		

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F 0584  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	During a review of the facilities policy titled Homelike Environment dated, revised 5/2017 indicated Policy Statement: Policy Statement Resident are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include e. clean bed and bath linens that are in good condition.		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45037</p> <p>Based on interview and record review, the facility failed to provide activities of daily living (ADL-such as bathing, showering, toileting, and mobility) for one of seven sampled residents (Residents 96).</p> <p>This failure resulted in Resident 96 feeling angry and had the potential to develop skin infections, skin irritation, and foul odor.</p> <p>Findings:</p> <p>A review of Resident 96's Admission Record indicated Resident 96 was readmitted to the facility on [DATE] with diagnoses including cerebral palsy (a condition that affects a person's ability to move, balance and maintain posture), and muscle wasting (the loss of muscle mass that occurs when muscles weaken and shrink).</p> <p>A review of resident 96's Minimum Data Set (MDS- a resident assessment tool) dated 11/27/24, indicated Resident 96's (cognitive skills- the core skills your brain uses to think, read, learn, remember, reason, and pay attention) for daily decision making was intact. The same MDS further indicated Resident 96 needed extensive assistance with Activities of Daily Living (ADLs, such bathing, showering, toileting, and mobility).</p> <p>A review of Resident 96's care plan dated 12/20/24, indicated Resident at risk for emotional distress related to: noted to be uncontrollably crying due to complain of not getting changed timely and dislikes nurse assigned to her during 3-11 shift.</p> <p>During an observation on 01/02/25 at 05:26 p.m., Resident 96 was observed sitting up in the bed watching TV in her room. Resident 96 stated the 3-11 shift nurses are not changing her in a timely manner. Resident 96 stated she is a Two person assist but the nurses on the night shift can't find assistance to provide her ADL care. Resident 96 further stated the Certified Nursing Assistant (CNA) and Restorative Nursing Assistant (RNA) are nurses from the registry. Resident 96 stated she was told the Hoyer lift was broken. Resident 96 stated [NAME] had not taken a shower in three weeks. Resident 96 stated when she calls for the nurse to come and change her diaper, she is waiting over 1 hour and sometimes she does not get changed at all. Resident 96 stated approximately 1 or two months ago she asked a CNA (no name given) to change her, the CNA walked out of her room and never came back the entire shift. Resident 96 stated she felt so embarrassed that she had to sit in urine the entire shift. Resident 96 stated she has talked to the Administrator and the Director of Nursing (DON) about it, and nothing had changed.</p> <p>During an interview on 01/03/25 at 07:13 a.m., Resident 96 stated she did not get showers on Tuesdays or Thursdays because the Hoyer Lyft was not working.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation with Licensed Vocational Nurse (LVN) 3, on 01/03/25 at 07:46 a.m., two Hoyer lifts were observed in the hallway. LVN 3 stated and confirmed that both Hoyer lifts are in good working condition. LVN 3 further stated if the Hoyer lifts are not working, he would call the Maintenance Supervisor or the on-call Maintenance Supervisor to come into the facility to fix it right away. LVN 3 further stated it might take 1-2 day to fix the Hoyer lifts.</p> <p>During an interview on 01/04/25 at 01:06 p.m., CNA/RNA 1 stated it was important to shower the residents on their shower days. CNA/RNA 1 further stated it is important to turn and changed residents to prevent them from getting sores especially if they can't turn themselves.</p> <p>During a concurrent interview and record review on 01/04/25 at 06:26 p.m., CNA/RNA 1, the facility's document titled CNA/RNA Assignment Sheet dated 11/1/24 and 11/6/24 were reviewed. The assignment sheet indicated Certified CNA/RNA 1 was assigned to care for Resident 96. The facility's document titled Scheduled CNA indicated CNA/RNA 1 was scheduled on 11/1/24 and 11/6/24.</p> <p>During a concurrent interview and record review on 01/04/25 at 07:02 p.m., with the Medical Record Director (MRD), there is no ADL charting in Resident 96's medical record for the month of November. The MRD confirmed the findings and stated there was no ADL charting in Resident 96's medical record for the month of November.</p> <p>During a concurrent record review and interview on 01/04/25 at 07:42 p.m., the DON reviewed Resident 96's record and stated, there is no ADL charting in Resident 96's medical records for the month of November. The DON stated every resident in the facility should have an ADL documentation in their medical record. The DON further stated, it is very important for all of the residents to receive ADL care to prevent having a foul odor, skin rashes, or skin breakdown.</p> <p>During a review of the facility's document titled Activities of Daily Living (ADL's), with a revised date of 3/2018, indicated Residents will be provided with care, treatment and services to maintain or improve their ability to carry out activities of daily living (ADL's). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45037</p> <p>Based on observation, interview, and record review, the facility failed to prevent skin surrounding the ostomy free of excoriation (abrasion, breakdown) to the colostomy ( a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body) site for one of seven sampled residents (Resident 114).</p> <p>This failure resulted in Resident 114's colostomy site and surrounding site to become excoriated and at risk for infection.</p> <p>Findings:</p> <p>A review of Resident 114's Admission Record indicate Resident 114 was admitted to the facility on [DATE] with diagnoses including colostomy malfunction (can occur when there are problems with the stoma, which is the opening in the abdominal wall created during a colostomy procedure) and gastro-esophageal reflux disease (a common condition in which the stomach contents move up into the esophagus).</p> <p>A review of Resident 114's History and Physical dated 11/01/24, indicated resident 114 has to capacity to make medical decisions.</p> <p>A review of Resident 114's Order Summary Report with an active date of 1/4/25, indicated colostomy care daily, check surrounding area for s/s of trauma and bleeding. Notify PMD if noted.</p> <p>During a review of Resident 114's Minimum Data Set (MDS- a resident assessment tool) dated 11/5/2024, indicated the resident was cognitively intact, and required assistance Activities of Daily Living ((ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 114's care plan dated 10/31/24, the care plan indicated: colostomy care daily, check surrounding area for signs and symptoms (S/S) of trauma and bleeding, notify primary medical doctor (PMD) if noted.</p> <p>During a concurrent observation and interview on 01/03/25 at 06:58 p.m., Resident 114' colostomy site was observed with Licensed Vocational Nurse (LVN) 2. The colostomy site was noted to be reddened and macerated. Resident 114 stated the nurses are not changing his colostomy bag as needed. Resident 114 further stated sometimes he go the whole day without his colostomy bag being changed and this makes him very angry that he had to go all day and night with his colostomy bag full of feces. Resident 114 stated his skin around his colostomy site is reddened because of his colostomy bag not being changed in a timely manner. LVN 2 stated she is from registry and confirmed the findings. LVN 2 further stated if the nurses are not changing Resident 114's colostomy bag as needed and as ordered it can cause redness, infection, and skin breakdown.</p> <p>(continued on next page)</p>		

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

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 01/05/25 at 10:07 a.m., the Treatment Nurse (TN) stated Resident 114's colostomy was supposed to be changed daily and as needed. The TN further stated if the nurses are not changing the resident's colostomy in a timely manner the resident can be susceptible (likely or liable) to skin breakdown, pain at the ostomy site, and infection.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled Colostomy/Ileostomy Care with a revised date of 10/2010, the P&amp;P indicated, Purpose: The purpose of the procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>44253</p> <p>Based on interviews and record reviews the facility failed to complete a post-hemodialysis (dialysis is the removing of waste, salt, and extra water to prevent build up in the body for residents who have loss of kidney function) assessment for one of 18 sampled residents (Resident 47).</p> <p>This deficient practice placed the resident at risk for a delay in detecting if the resident had a non-functioning arteriovenous shunt (AV- a connection or passageway between an artery and a vein used for hemodialysis) and a delay in detecting complications including infections and bleeding.</p> <p>Findings:</p> <p>A review of Resident 88's admission record indicated the facility originally admitted the resident on 10/14/2022 and readmitted the resident on 6/7/2024 with diagnoses that included end stage renal disease (ESRD - loss of kidney function in which the kidneys no long work to meet the body's needs) and dependence on renal dialysis (the process of removing waste products and excess fluid from the body using a machine when the kidneys are not able to do so) and diabetes (high blood sugar).</p> <p>A review of the Physician's History and Physical (H&amp;P) dated, 8/9/2024, indicated Resident 88 had the capacity to understand and make medical decisions. The H&amp;P indicated Resident 88 was diagnosed with ESRD and was on hemodialysis.</p> <p>A review of Resident 88's Order Summary Report indicated the physician ordered on 8/19/2024, the resident to receive dialysis on Tuesdays, Thursdays, and Saturdays; Access site; Left upper arm AV Shunt.</p> <p>A review of Resident 88's Order Summary Report indicated the physician ordered on 8/20/2024, facility staff to monitor the resident's left AV shunt for bruit (sound of blood flowing through the AV shut) and thrill (palpable blood flow through the AV shunt) every day and to remove AV fistula shunt dressing four to six hours after dialysis treatment every Tuesday, Thursday, and Saturday.</p> <p>A review of Resident 88's dialysis care plan initiated 8/20/2024, indicated the resident required dialysis due to renal failure. The care plan goal was for the resident to have immediate intervention should any sign or symptom of complications from dialysis occur. The interventions included to monitor vital signs and notify the physician of significant abnormalities, monitor/document/report signs and symptoms of infection to access site as needed. The care plan indicated the signs and symptoms of infection to the access site included redness, swelling, warmth or drainage.</p> <p>A review of the Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 10/20/2024 indicated Resident 88's cognition (ability to think, understand, and reason) was intact. The MDS indicated Resident 88 required partial/moderate assistance from staff with dressing, toileting hygiene and bathing. The MDS indicated Resident 88 was receiving dialysis treatment.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facilities dialysis communication forum indicated it was a three-section form. The first section was the pre dialysis assessment to be completed by the facility. The second section was for the dialysis unit to fill out. The third section was the facility's post hemodialysis assessment to be completed by the receiving nurse when the when the resident returned from dialysis. A further review of the post hemodialysis section included an assessment of the resident's mental status, AV sunt, bruit, thrill, AV shunt dressing, breath sounds and vital signs.</p> <p>During a concurrent interview and record review of Resident 88's dialysis binder with Registered Nurse Supervisor 2 (RNS 2). RNS reviewed the resident's dialysis binder and stated the resident's dialysis communication forms did not have a post dialysis assessment on the following dates: 8/12/2024, 9/17/2024, 10/1/2024, 11/12/2024, 12/17/2024 and 12/30/2024. RNS 2 stated once the resident returned from dialysis, the nurse was to complete the post dialysis assessment. RNS 2 stated the assessment had to be completed because dialysis could cause hypotension and the resident's vital signs could become unstable. During a concurrent review of Resident 88's nurse's notes, RNS 2 stated there were no progress notes that indicated the nurse documented the post dialysis assessment in the resident's electronic health record.</p> <p>During an interview on 1/5/2025 at 6:00 PM, the Director of Nursing (DON) stated the dialysis communication form was to monitor's the resident's vital signs prior to and after dialysis. The DON stated not assessing the resident upon return from dialysis could result in the facility not addressing changes in the resident's health condition.</p> <p>A review of the facility's policy and procedure titled, Hemodialysis Access Care, reviewed 1/25/2024, under the section Documentation indicated:</p> <p>The General Medical nurse should document in the resident's medical record every shift as follows:</p> <ol style="list-style-type: none"> <li>1. Location of catheter.</li> <li>2. Condition of dressing (interventions if needed).</li> <li>3. If dialysis was done during shift.</li> <li>4. Any part of report from dialysis nurse post dialysis is being given.</li> <li>5. Observations post dialysis.</li> </ol>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>45455</p> <p>Based on interview and record review, the facility failed to ensure the social service designee follow up with the sending facility (F2) the resident's personal belonging for one out of 30 sampled Residents (Resident 48)</p> <p>This deficient practice had the potential for personal property misplaced and or lost.</p> <p>Findings:</p> <p>A review of Resident 48's Admission Record, indicated F1 originally admitted Resident 48 on 4/25/2024, with diagnoses that included, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side (weakness or paralysis on the left side of their body due to a stroke that damaged the right side of their brain), muscle wasting and atrophy (the loss or thinning of muscle tissue), hyperlipidemia (a medical condition characterized by abnormally high levels of lipids (fats) in the blood), hypertension (High blood pressure), and morbid obesity (A serious health condition that results from an abnormally high body mass that is diagnosed by having a body mass index (BMI) greater than 40).</p> <p>A review of Resident 48's history and physical (H&amp;P) dated 4/25/2024 indicated Resident 48 can make needs known but cannot make medical decisions.</p> <p>A review of Resident 48's A review of the Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 10/31/2024, indicated Resident 48's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact for daily decision making.</p> <p>During a facility tour on 1/4/25 at 4:53 PM, Resident 48 stated she has been requesting assistance from the Social Services Designee (SSD) in getting her personal belongings from previous skilled nursing facility (F2) and had not received any update on the status of her personal belongings. Resident 48 stated she is on the verge of giving up on every getting her belongings back from the F2.</p> <p>During an interview on 1/4/25 at 3:15 PM, SSD stated she called the F2, and their staff (unable to recall name) stated they had already sent Resident 48's belongings to F2. SSD was unable to provide a date, the individual she spoke to from F2 who stated they sent Resident 48's belongings to the facility, and/or supporting documentation from F2 proving they had delivered Resident 48's belongings to facility. SSD further stated if a Resident's reports missing belongings, she (SSD) will review the Residents belonging list, will try to look for it round the facility, in the Residents room and closet and in the facility laundry area. SSD stated if she is unable locate the missing belongings, then the facility will replace the missing belongings.</p> <p>A review of facility policy and procedure titled Social Services revised date 2010, indicated, the facility provides medically-related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being .</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c. Assisting in providing corrective action for the resident's needs by developing and maintaining individualized social services care plans;</p> <p>i. Making supportive visits to residents and performing needed services (i.e., communication with the family or friends, coordinating resources and services to meet the resident's needs);</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>45037</p> <p>Based on observation and interview, the facility failed to ensure the facility staff stored and discard controlled (s (medications that the use and possession of are controlled by the federal government), and non-controlled medications properly as indicated in the facility's policy and procedures (P&amp;P) titled Controlled Medication Disposal.</p> <p>This failure had the potential to result in lack of accountability for these medications, and presented a potential for the diversion of the controlled substances</p> <p>Findings:</p> <p>During a concurrent observation and interview on 01/04/25 at 8:07 a.m., of the facility's medication storage room with Registered Nurse Supervisor (RNS) 1, RNS 1 stated expired medications are being destroyed by two-night shift License Nurses. RNS 1 further stated the disposal of narcotics are to be destroyed by the Director of Nursing (DON) and stored in the DON's office.</p> <p>During a concurrent observation and interview on 01/04/25 at 8:37 a.m., with the DON, it was noted that the storage container for the narcotics was not a locked permanently or locked affixed compartment. It was observed that the compartment was open and easily accessible to extract medication from. The DON stated the medications should be in a locked container prevent diversion.</p> <p>During an interview on 01/05/25 at 09:59 a.m., the DON stated the process of narcotics disposition starts with the charge nurses. The DON stated the narcotics are first counted by two licenses before they remove the medication from the medication carts, the license nurse gives the medications to the DON and then the narcotics are double locked in the DON's office until the pharmacist comes in the facility to waste the medication. The DON stated the pharmacist verified the medications with the DON and then it is put into an incinerator (an apparatus for burning waste material, especially industrial waste, at high temperatures until it is reduced to ash), and the pharmacist will seal the container to prevent diversion. The DON further stated the company picks up the medication and signed that they picked up the medication. The DON did not have a log/record of the dates, times, and contact pharmacist that comes to the facility to waste controlled medications, or of the company that pick up the controlled medications.</p> <p>During a review of the facility's policy and procedures (P&amp;P) titled Controlled Medication Disposal with an effective date of 4/2021, the P&amp;P indicated, Procedures: e. Since Alliance Pharmacy only facilitates the destruction, all destruction logs will be performed and maintained at the facility. The facility shall be responsible for all records and those records must be maintained for at least three years.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure safe and sanitary food storage and preparation practices when:</p> <ol style="list-style-type: none"> <li>[NAME] 1's cell phone and speaker were placed on the preparation sink (prep sink: area where food is prepared).</li> <li>Opened bags of hashbrowns in the kitchen's chest freezer were not labeled with an open date.</li> <li>Dietary Aide (DA1) loaded dirty pots and pans into the dish machine and then removed cleaned and sanitized dishes to air dry without washing hands between the two actions.</li> </ol> <p>These deficiencies had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could place the residents at risk for food borne illness or contamination.</p> <p>Findings:</p> <p>During an observation in the prep sink area of the kitchen and interview on[DATE] at 5:04 PM, a cell phone and personal speaker were observed on the prep sink. [NAME] 1 stated the items belonged to [NAME] 1 and [NAME] 1 removed the items from the area. [NAME] 1 stated personal items should not be in the kitchen area for infection control.</p> <p>During a concurrent interview and observation in the dish machine area on [DATE] at 5:17 PM Dietary Aide (DA1) was loading dirty pots and pans in the dish machine. Then DA1 was removing the cleaned and sanitized dishes to air dry without washing hands between the two actions. DA 1 confirmed not washing hands after touching the dirty dishes and prior to putting away clean dishes. DA 1 stated they should have washed hands to prevent cross contamination.</p> <p>During a concurrent interview and observation on [DATE] at 5:24 PM with the Dietary Services Supervisor (DSS) the kitchen's chest freezer was observed. The DSS stated the hashbrowns inside the freezer were in open bags without open dates and should have been dated. The DSS stated the date the hashbrowns were opened was unknown. The DSS stated the not labeling the hashbrowns, having personal outside items on the prep sink, and the dietary aide not washing hands between touching dirty and clean dishes all could lead to foodborne illness.</p> <p>During an interview on [DATE] at 5:56 PM, the Director of Nursing (DON) stated food in the kitchen were to be labeled with opened date so that the residents didn't receive expired foods.</p> <p>A review of facility policy titled Sanitization, reviewed [DATE], indicated, The food service area shall be maintained in a clean and sanitary manner.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of facility Procedure for Refrigerated Storage, dated 2020, indicated individual packages of refrigerated or frozen food taken from the original packing box need to be labeled and dated. Freezer burn may occur before that and reduce the maximum shelf life.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455</b></p> <p>Based on observation, interview, and record review, the facility staff failed to observe infection control measures by:</p> <ol style="list-style-type: none"> <li>1. Storing a clean bedside table, clean linen and a wheelchair in the bathroom for one out of nine bathrooms (room [ROOM NUMBER]'s bathroom).</li> <li>2. Failing to doff used gloves after applying topical medication to a resident in room and then went out in the hallway for one out of five Licensed Vocational Nurse (LVN 5).</li> </ol> <p>These deficient practices had the potential to cause cross contamination and spread infections to the facility.</p> <p>Findings:</p> <p>During a facility tour on 1/2/25 7:22 PM a bedside table was observed to have clean linen inside the bathroom of Resident room [ROOM NUMBER]. During concurrent interview, Certified Nursing Assistant (CNA2) stated she did not know who placed the bedside table, clean linen, and a wheelchair inside room [ROOM NUMBER]'s bathroom. CNA2 further stated the items are not supposed to be in the bathroom, because of infection control.</p> <p>During a facility tour on 1/3/2025 6:35 PM Licensed Vocational Nurse (LVN 5) was observed walking out of room [ROOM NUMBER] and to a medication cart outside the room while wearing gloves with a topical medication cream Diclofenac sodium (pain medication) belonging to a resident in hand. During a concurrent interview with LVN 5 stated she (LVN 5) is not supposed to have gloves and holding medication in the hallway because of infection control. room [ROOM NUMBER] was observed to have an enhanced barrier precaution sign at the entrance, LVN 5 stated she did not know which Resident in room [ROOM NUMBER] was on enhanced precaution.</p> <p>During an interview on 1/5/2025 at 6 PM, Director of Nursing (DON) stated wheelchairs, bedside tables and clean linens should not be inside Resident's bathrooms because they can get contaminated and if used could pause an infection control issue for the Residents. DON further stated staff should doff personal protective equipment (PPE) and place it in the trash before exiting the Residents room to prevent spread of diseases.</p> <p>A review of facility policy and procedure (P&amp;P) titled infection control dated 1/25/2024 indicated, facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.</p>		

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<p>F 0907</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough space and equipment to meet each resident's needs</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45037</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure that the elevator was in safe working condition.</p> <p>This failure had the potential to cause harm to the residents, staff, and visitors.</p> <p>Findings:</p> <p>During an observation on 1/4/2025, at 12:25 p.m., the Monitor Aide (MA) was observed seated by the facility elevator back exit and Garage exit on the 1st floor. The MA stated he was monitoring the exits for possible elopement. The MA further stated the elevator would sometimes stop functioning. The MA stated when the elevator stops functioning, he notifies the receptionist to come monitor the exits for potential elopements while he (MA) would go inside the parking garage to reset the breaker for the elevator to function again. The MA stated this happens at least 3-4 times during his 7am-3pm work shift. The MA stated the Maintenance Supervisor, Administrator, and all of the Nursing Supervisors are aware of the elevator not functioning properly.</p> <p>During an interview on 1/4/2025 at 5:19 p.m., the Certified Nursing Assistant (CNA) 1, stated they had previously been stuck in the elevator for about two minutes. CNA 1 stated staff get stuck frequently.</p> <p>During an interview on 01/05/25 at 06:39 p.m., Director of Nursing (DON) stated he is aware of the elevators not working properly. Stated he is in the process of discussing the issue with the elevators with the corporate office to see how soon the elevator can be repaired. DON stated if the staff or a resident get stuck on the elevator, they can get injured or be fearful of using the elevators.</p> <p>During a concurrent interview and record review on 01/05/25 at 07:13 p.m., the Maintenance Assistant (MA) stated the facility's elevator had not been working properly for at least one year. The MA stated he has gotten stuck in the elevator many times for about 1-3 minutes. The MA stated the last time he was stuck in the elevator was approximately two days ago and multiple employees had gotten stuck in the elevator daily. The MA further stated if a person gets stuck on the elevator another staff will reset the elevator so that the doors can properly open. The MA further stated the elevator company came out to the facility on [DATE] as an urgent request, to inspect the elevators and gave the Administrator the invoice and the cost to repair the elevator. The MA further sated as of today the elevator is has not been repaired.</p> <p>A review of the facility's document titled Golden State Elevator Service, dated 8/29/24, indicated Urgent Request work order #5919 for Facility Name and location On your Located: Passenger Elevator. The document further indicated the door equipment is original equipment. It has become very troublesome; it is out of date. Golden State Elevator highly recommends the updating meet all current elevator codes.</p> <p>(continued on next page)</p>		

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<p>F 0907</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the facility's policy and procedures (P&amp;P) titled Maintenance Service with a revised date of 12/2009, the P&amp;P indicated, Policy Interpretation and Implementation: 1.The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.</p>

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  01/05/2025
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.			
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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>44253</p> <p>Based on observation, interview, and record review the facility failed to ensure the industrial washing machine used to wash facility linen for residents was in operating condition to provide clean linen daily and as needed for all facility residents.</p> <p>This deficient practice had the potential to result in a significant delay in providing clean and sanitary linen for all 111 medically compromised residents.</p> <p>Cross reference: F584</p> <p>Findings:</p> <p>During an observation of the laundry service area on 1/4/2025 at 4:03 pm, the laundry room was clean, no water on the floor, or rust on the pipes, machine lint traps clean, folding area full of unfolded clothes, one laundry service worker on duty, LSW 1. Laundry room had two industrial size washing machines, with one industrial washing machine was not working.</p> <p>During an interview on 1/4/2025 at 4:13 pm with Assistant Maintenance Supervisor (AMS) and Assistant Laundry Supervisor (ALS), the ALS stated he was temporarily in charge of the laundry service as acting laundry services supervisor. AMS stated that the washing machine had been out of service for about a month. AMS stated the industrial washing machine needed a part that was being ordered. AMS was not familiar with how to install the ordered part, and someone will have to be sent to the facility to install the part on the machine. AMS stated until then there was only one machine used to wash the linen for the facility.</p> <p>During observation on 1/5/2025 4:10 pm the laundry room had two industrial size laundry machines and one small commercial size washing machine; in addition, the laundry room had two industrial size drying machines. One of two industrial washing machines was out of service. The machine to the right side of the laundry room was empty and the electronic display read Error scrolling across the screen continually. The laundry room had one bin full of dirty linen and the working industrial washer was washing a full load of facility linen. The small commercial size washer was not in use at the time, however, according to laundry worker 1 (LW 1) the small commercial size washing machine was in working condition.</p> <p>During an interview on 1/5/2025 at 4:12 LW 1 stated, the industrial size laundry machine had not been working for over three weeks. LW 1 stated that some time prior, someone went out to fix the industrial washing machine, however, they stated that a part needed to be ordered and someone needed to install the part before the machine could be used again.</p> <p>During an interview on 1/5/2025 4:23 pm the Director of Nursing (DON) was not sure if the part to fix the machine had been ordered, or an appointment for a repair person was scheduled. The DON stated he would check to see if a technician was scheduled to come out to fix the machine or if the part was ordered. The DON stated, if there was only one machine, it could cause a delay in delivering clean linen to the staff in the resident care area. The DON stated the shortage of clean linen could cause the residents to feel some frustration due to a delay in having their linen changed.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's Policy and Procedure (P&amp;P) titled Maintenance Service dated revised 12/2009, indicated Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation 1. The maintenance department is responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a. maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. B. maintaining the building in good repair and free from hazards. D. maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. F. establishing priorities in providing repair service. 3. The maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45037</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of seven sampled residents (Resident 68) did not have a broken trim on the wall near his bed, missing knobs to his closet door, and a exposed wire that ran from his television to the window in room [ROOM NUMBER].</p> <p>This failure had the potential to put Resident 68 at risk for injury.</p> <p>Findings:</p> <p>A review of Resident 68's Admission Record, indicated Resident 68 was admitted to the facility on [DATE] with diagnoses that included but not limited to cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it) and hyperlipidemia (excess of lipids or fat in your blood).</p> <p>During an observation and interview on 01/03/25 at 7:11 p.m., Resident 68 was observed lying in bed watching television (TV). Resident 68 stated the broken trim on the wall near his bed was like that when he was admitted to room [ROOM NUMBER]. Resident 68 further stated the walls and the missing knobs, and the wire that is running from his television to the window was like that when he was admitted to room [ROOM NUMBER]. Resident 68 stated the Maintenance Supervisor (MS) never fix anything in his room. Resident 68 further stated it makes him frustrated to wake up everyday and look at all of the things that need repairing in his room.</p> <p>A review of Resident 68's Physician History and Physical dated 4/25/24, indicated Resident 68 was oriented to person, place, and time.</p> <p>A review of the Minimum Data Set (MDS, a resident assessment tool) dated 11/4/24, indicated Resident 68 had the capacity to understand and make some decisions. Resident 68's cognition (thought process) is mildly impaired, and she required extensive assistance in dressing, mobility, transfer, and toilet use.</p> <p>During a concurrent observation and interview on 01/03/25 at 07:11 p.m., of room [ROOM NUMBER] with Maintenance Assistant (MA) was observed with peeling paint on the walls, noted with bent trim on the wall near the Residents 68's bed, wire leading from Resident 68 television to the window, knob missing from the Resident 68's closet door. The MA stated he had been employed with the facility for one year. The MA stated the Maintenance Supervisor (MS) resigned approximately one week ago, and he do not know what needs to be repaired throughout the facility because the MS did not leave a repair list, binder, or give him any verbal instructions. The MA further stated with the trim on the wall being bent like that the residents can injure themselves. The MA stated he do not know why there is a wire running from Resident 68's TV leading to the window.</p> <p>During a review of the facility's Policy and Procedures (P&amp;P) titled Maintenance Service with a revised date of 12/2009, the P&amp;P indicated, Policy Interpretation and Implementation:</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.</p> <p>2. Functions of maintenance personnel include, but are not limited to:</p> <p>b. Maintaining the building in good repair and free from hazards.</p>

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>44253</p> <p>Based on interview and record review, the facility failed to ensure staff receive required abuse training for one of five employees (Sitter 1 [STR 1]), who did not receive abuse training upon hire on 6/18/24.</p> <p>This failure has the potential to delay identification or protection of residents from possible abuse, neglect, and exploitation.</p> <p>Findings:</p> <p>A review of STR 1's employee file indicated STR 1 was hired on 6/18/2024. A review of STR 1's in-service trainings indicated STR 1 did not receive training on abuse upon hire.</p> <p>During an interview on 1/4/2025 at 1:16 PM, STR 1 stated he has been employed by the facility since June 2024. STR 1 stated received abuse training in December 2024 after a resident made an allegation of abuse.</p> <p>During a concurrent interview and record review on 1/4/2025 at 5:56 PM, STR 1's employee file was reviewed with the facility's staffer (STFR - person that prepares the work schedule for the facility's employees). The STFR stated there was no evidence STR 1 received abuse training upon his hire on 6/18/2024. STFR stated STR 1 was in-serviced on abuse on December 2024 after a resident made an allegation of abuse against STR 1. STFR stated employees were given abuse training upon hire. The STFR stated not providing abuse training upon hire could lead to the abuse and neglect of residents due to the staff not knowing what constitutes abuse and neglect.</p> <p>During an interview on 1/05/2025 at 5:58 PM, the Director of Nursing (DON) stated abuse in-services were to be completed upon hire. The DON further stated abuse in-services were given to educate the staff and nurses on the types of abuse and to guide them when interacting with residents. The DON stated not giving abuse in-service could lead to abuse.</p> <p>The facility's policy and procedure titled, Abuse Prevention/Prohibition, reviewed 1/25/2024, indicated the facility conducts mandatory Facility Staff training programs during orientation, annually and as needed on:</p> <ul style="list-style-type: none"> <li>- Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation.</li> <li>- Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident's property.</li> <li>- Recognizing signs of abuse, neglect, exploitation, and misappropriation of resident property, such as physical or psychosocial indicators.</li> </ul> <p>(continued on next page)</p>

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Reporting abuse, neglect, exploitation, and misappropriations of resident property, including injuries of unknown sources, and to whom and when staff and others must report their knowledge related to any alleged violation without fear of reprisal.</p>		