

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/29/2024
NAME OF PROVIDER OR SUPPLIER  Ararat Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  2373 Colorado Blvd. Los Angeles, CA 90041	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>36925</p> <p>Based on interview and record review, the facility failed to provide sufficient monitoring and supervision to one of three sampled residents (Resident 1) who had an unwitnessed fall on 4/11/24.</p> <p>This deficient practice resulted to a laceration on the head and above the right eye of Resident 1 that needed medical attention.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated the facility initially admitted the resident on 9/22/23 with diagnoses including congestive heart failure (a long-term condition in which the heart could not pump blood well enough to meet the body's needs).</p> <p>A review of Resident 1 ' s History and Physical assessment, dated 9/23/23, indicated that the resident did not have the capacity to understand and make decisions for herself.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and screening tool), dated 3/27/24, indicated that the resident ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was severely impaired and the resident needed moderate to maximum assistance (helper does more than half the effort) from a person to perform daily living activities such as personal hygiene.</p> <p>A review of Resident 1 ' s Progress Notes, dated 4/11/24 at 4:49 AM, indicated that at around 3:15 AM, CNA 1 informed Registered Nurse 1 (RN 1), that she found Resident 1 on the floor next to her bed. The progress notes indicated that Resident 1 sustained a laceration above the right outer side of her eye and on her head, with a moderate amount of blood on the floor next to her.</p> <p>A review of the Witness Statement provided by CNA 1 on 4/11/24 indicated that when she came back from her break at 3:15 AM, she checked on Resident 1 and found her on the floor.</p> <p>A review of the Witness Statement provided by RN 1 on 4/11/24 indicated that at around 3:15 AM, CNA 1 called her to come to the room of Resident 1 because the resident had an unwitnessed fall. RN 1 indicated on her statement that the resident was confused but verbally responsive.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/25/24 at 12:20 PM, during an observation, Resident 1 was on her bed having lunch. Resident 1 had a light bruise on her right eye and was on an oxygen concentrator, had a floor mat on both sides of the bed, and the bed had no side rails.</p> <p>On 4/25/24 at 2:10 PM, during an interview with CNA 3, CNA 3, stated that Resident 1 does not use the call light. CNA 3 stated Resident 1 would call staff if she needs help.</p> <p>During a telephone interview on 4/29/24 at 10:26 AM, CNA 1 stated that she worked during the 11-7 AM shift on 4/10/24 and at the beginning of the shift, she informed RN 1 that Resident 1 was awake, confused, and agitated.</p> <p>At around 3:15 AM, CNA 1 stated that she went on her break and found Resident 1 on the floor near her bed when she returned to check the resident. She stated that she immediately notified RN 1 who called 911 and transferred the resident to the hospital.</p> <p>During a telephone interview on 4/29/24 at 10:45 AM, RN 1 stated that she worked during the 11-7 AM shift on 4/10/24 and at the beginning of the shift (around 11 AM to 12 AM), Resident 1 was sleeping when she conducted her rounds. RN 1 stated that she informed the CNAs to call her if Resident 1 wakes up and starts to hallucinate. RN 1 stated that no one informed her that Resident 1 woke up confused and agitated on 4/10/24, prior to the resident's fall.</p> <p>During the same interview, RN 1 stated that on 4/10/24, during th 11-7 shift, she was at the Nursing Station when CNA 1 informed her at around 3:15 AM that she found Resident 1 on the floor near her bed. RN 1 stated that she always tells the CNAs during her shift to inform her whenever the resident wakes up agitated because she knows that the resident randomly becomes confused and agitated when she awakens. RN 1 stated that CNA 1 did not inform her that Resident 1 was confused or agitated during her shift on 4/10/24, prior to the fall.</p> <p>A review of the facility ' s undated policy titled, Fall Risk Assessment, version 1.0, indicated that the facility will ensure that each resident receives adequate supervision and assistance to prevent accidents.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>36925</p> <p>Based on observation, interview, and record review, the facility failed to assess the medical need for the use of a bed side rail for one of three sampled residents (Resident 1) that resulted to an unwitnessed fall.</p> <p>This deficient practice made Resident 1 suffer a laceration above her right eye and on her head that required medical attention.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated the facility initially admitted the resident on 9/22/23 with diagnoses including congestive heart failure (a long-term condition in which the heart could not pump blood well enough to meet the body's needs).</p> <p>A review of Resident 1 ' s History and Physical assessment, dated 9/23/23, indicated that the resident did not have the capacity to understand and make decisions for herself.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and screening tool), dated 3/27/24, indicated that the resident ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was severely impaired and the resident needed moderate to maximum assistance (helper does more than half the effort) from a person to perform daily living activities such as personal hygiene.</p> <p>A review of Resident 1 ' s Progress Notes, dated 4/11/24 at 4:49 AM, indicated that at around 3:15 AM, CNA 1 informed Registered Nurse 1 (RN 1), that she found Resident 1 on the floor next to her bed. The progress notes indicated that Resident 1 sustained a laceration above the right outer side of her eye and on her head, with a moderate amount of blood on the floor next to her.</p> <p>A review of Resident 1 ' s chart indicated that the facility did not do a Side Rail Utilization Assessment (an assessment form completed by a licensed nurse to determine if the use of a side rail is needed by the resident) during the resident ' s stay in the facility.</p> <p>A review of the Witness Statement provided by CNA 1 on 4/11/24 indicated that when she came back from her break at 3:15 AM, she checked on Resident 1 and found her on the floor.</p> <p>A review of the Witness Statement provided by RN 1 on 4/11/24 indicated that at around 3:15 AM, CNA 1 called her to come to the room of Resident 1 because the resident had an unwitnessed fall. RN 1 indicated on her statement that the resident was confused but verbally responsive.</p> <p>During an observation on 4/25/24 at 12:20 PM, Resident 1 was sitting on her bed, confused, and was having lunch. Resident 1 did not have a side rail on both sides of the bed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview with the Social Services Director (SSD), she stated, We do not use side rails because it is against the regulation.</p> <p>During an interview on 4/25/24 at 3:31 PM, the Director of Nursing (DON) stated, A side rail would help prevent a fall, but it is against the regulation to use them.</p> <p>During an interview on 4/25/24 at 4:06 PM, the SSD stated that the beds in the facility when she started working in 2/2021 had no side rails. She stated the facility does not do a side rail assessment because they do not use side rails unless there is a need.</p> <p>During an interview on 4/29/24 at 1:10 PM, RN 2 stated that Resident 1 does not have a Side Rail Utilization Assessment on file.</p> <p>During a telephone interview on 4/29/24 at 10:26 AM, CNA 1 stated that she worked during the 11-7 AM shift on 4/10/24 and at around 3:15 AM, she went on her break and found Resident 1 on the floor near her bed when she returned to check the resident.</p> <p>During a telephone interview on 4/29/24 at 10:45 AM, RN 1 stated that on 4/10/24, during th 11-7 shift, she was at the Nursing Station when CNA 1 informed her at around 3:15 AM that she found Resident 1 on the floor near her bed. RN 1 stated that she always tells the CNAs during her shift to inform her whenever the resident wakes up agitated because she knows that the resident randomly becomes confused and agitated when she awakens. RN 1 stated that CNA 1 did not inform her that Resident 1 was confused or agitated during her shift on 4/10/24, prior to the fall.</p> <p>On 4/29/24 at 1:10 PM, during a concurrent interview and record review with RN 2, she stated that RN 1 transferred Resident 1 to the acute hospital at around 4 AM, immediately after the unwitnessed fall on 4/11/24. RN 2 stated that Resident 1 was not in the facility when she arrived at 6:45 AM and the resident returned from the hospital at 8:30 AM on the same day. RN 2 stated that Resident 1 has episodes of confusion and agitation every one or two weeks. During a concurrent record review of the resident ' s care plan, RN 2 confirmed that there was no care plan in place to address the resident ' s behavior for confusion and agitation. RN 2 stated that the facility does a Fall Risk Assessment during admission, quarterly, and after a fall incident.</p> <p>A review of Resident 1 ' s Fall Risk Assessment with RN 2, dated 4/11/24, indicated that Resident 1 had no history of falls. RN 2 stated that she did the Fall Assessment for Resident 1 on 4/11/24 and admitted that she should have indicated that the resident had a previous fall in the last 30 days and that the resident has a predisposing disease, that would significantly affect the total score of the assessment. RN 2 stated that the total score of Resident 1 during that Fall Risk Assessment should have been 14 instead of 8. The Fall Risk Assessment tool indicated that a resident with a score of over 10 was considered a High Risk for fall.</p> <p>A review of the facility ' s undated policy titled, Side Rails, version 5.0, revised on 10/24/22, indicated that the purpose of the policy is to determine the appropriateness of bed rail use for individual residents. The policy indicated that the Side Rail Utilization Assessment form must be completed by a licensed nurse to find out if the use of side rails is necessary.</p>		