STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555126	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ararat Convalescent Hospital	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854 Based on interview and record review, the facility failed to meet professional standards of practice for one of three sampled residents (Resident 1), who sustained an unknown injury, when Resident 1 was found with swelling on the left cheek from an unknown cause. The facility failed to conduct neurological assessments (series of tests that evaluate a patient's nervous system function) and develop a care plan. As a result of these deficient practices, Resident 1 had the potential to suffer further deterioration of health. Findings: A review of Resident 1 ' s Admission Record indicated the resident was admitted on [DATE] with diagnoses that included metabolic encephalopathy (a change in how the brain works due to an underlying condition), Parkinson ' s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and muscle weakness. A review of Resident 1 ' s History and Physical (H&P), dated 9/19/2024, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 1 ' s Minimum Data Set (a federally mandated resident assessment tool), dated 9/22/2024, indicated the resident has severe cognitive impairment. A review of Resident 1 ' s Incident Note, dated 10/6/2024, timed at 9:32 PM, signed by the Director of Staffing Development (DSD), indicated Resident 1 was observed with light blue colored swelling on left cheek that was noted with 2 small red spots on it. The notes added Resident 1 had light discoloration on lower lip. A review of the facility ' s investigation conclusion, dated 10/10/2024, signed by Administrator (ADM), indicated when Resident 1 was interviewed regarding the cause of the swelling, Resident 1 responded that she fell outside. A review of resident ' s entire medical chart did not indicate documented evidence that NA was conducted to assess Resident 1 in response to Resident 1 ' s left cheek injury. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s entire care plans did not indicate documented evidence that a care plan was developed in response to Resident 1 ' s left cheek injury that would have included goals and interventions for facility staff to follow to address the resident ' s left cheek injury. During an interview on 10/17/2024 at 10:42 AM with Licensed Vocational Nurse (LVN), LVN stated when a resident sustains an injury of unknown cause that involves the head or face, NA must be conducted. During an interview on 10/17/2024 at 1:08 PM with Registered Nurse (RN), RN stated when a resident sustains a new injury such as Resident 1 ' s left cheek swelling, a care plan must be developed. RN stated when an injury that involved the head or face is observed, the resident must undergo NA by the nurses and the assessments logged into the Neurological Flow Sheet. During a concurrent interview and record review on 10/17/2024 at 1:12 PM with RN, Resident 1 ' s entire medical records were reviewed. RN stated there is no evidence in Resident 1 ' s chart that a care plan was developed to address Resident 1 ' s left cheek swelling. RN stated there is also no evidence that NA were conducted in response to Resident 1 ' s left cheek swelling. RN stated NA is more extensive than regular monitoring conducted by nurses because NA involves more tests. During an interview on 10/17/2024 at 1:32 PM with DSD, DSD stated NA should be conducted when head injuries are suspected, such as in the case for Resident 1. DSD stated if NA is not conducted, the resident ' s health could deteriorate because the resident would not be adequately monitored for serious injuries like a bleed in the brain or vision problems. DSD further stated care plans should be initiated for any injuries because care plans serve as a plan for staff to follow. DSD stated failure to not develop a care plan can lead to staff to not provide adequate care to the resident. A review of the facility ' s P&P titled, Care Planning, revised 10/24/2022, indicated care plans serve to help the resident move toward resident-specific goals that address the resident ' s medical, nursing, mental, and psychosocial needs. The P&P also indicated the care plan will describe services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being. The P&P also indicated changes may be made to the care plan on an ongoing basis for the duration of the resident ' s stay. A review of the facility ' s policy and procedure (P&P) titled, Neurological Assessment, revised 8/1/2014, indicated nursing staff will perform NA following a fall or other accident/injury involving head trauma. The P&P also indicated nursing staff will perform NA following an unwitnessed fall. The P&P indicated NA consists of tests that include determining the resident ' s level of consciousness and pupillary activity (refers to the size of a part of the eye called the pupil and how it changes in response to different stimuli). The P&P further stated early signs of neurological compromise includes changes in the resident ' s level of consciousness and pupillary activity. A review of the facility ' s P&P titled, Response to Falls, revised 3/1/2015, indicated the licensed staff will complete the NA using the Neurological Flow Sheet for any un-witnessed fall with known head injury for 72 hours following the fall.