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	11/14/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview, and record review, the facility failed to ensure to maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease by failing to: 1. Ensure Certified Nurse Assistant (CNA) 1 removed her personal protective equipment (PPE, specialized equipment such as gown, gloves, and mask that minimize exposure to hazards that may cause illness) before leaving a designated isolation room. 2. Ensure CNA 2 used proper hand hygiene in between Resident 8 and Resident 3 ' s room. 3. Ensure Kitchen Assistant [KA] wore gloves when handling and preparing food/drink in the kitchen. 4. Family Visitor (FM) 2 observed walking into the facility and resident hallway without wearing a surgical mask. 5. Ensure Certified Nursing Assistant (CNA) 6 performed hand hygiene when touching Resident 24 ' s wheelchair and food tray for lunch. 6. Ensure CNA 7 donned personal protective equipment (PPE) when entering a contact isolation (used for patients with disease caused by microorganisms [bacteria and viruses] that are spread through direct and indirect contact) room and performed hand hygiene when touching Resident 2 ' s food tray and resident food cart. 7. Ensure Activities Staff (AS) performed hand hygiene when touching Resident 6 ' s walker and chairs in the dining/activity room. 8. Housekeeping (HK) 1 did not change gloves when sweeping and mopping the floor, touching Resident 16 ' s bed control remote, cleaning and disinfecting Resident 16 ' s floor mat, and touching Resident 16 ' s bedside table in Resident 16 ' s room. Resident 16 was under Contact Precautions (a set of steps to prevent the spread of infectious diseases through direct or indirect contact with a patient or their environment). (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: 555126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Ararat Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 2373 Colorado Blvd. Los Angeles, CA 90041	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Certified Nursing Assistant (CNA) 4 did not wear a gown when picking up Resident 7 ' s food tray, who was having gastrointestinal (GI, the body system that takes in food and liquids and break them down into substances that the body can use for energy, growth, and repair) symptoms. Then, CNA 4 went to Resident 19 ' s bed and picked up Resident 19 ' s food tray. Resident 19 did not have GI symptoms. 10. Family Member (FM) 1 did not follow the facility ' s Contact Precautions when visiting Resident 14, who was having GI symptoms. 11. The facility did not report the GI outbreak timely. These deficient practices had the potential to result in the infection spread throughout the facility. In additon, this failure resulted in a Gastrointestinal Illness (GI) outbreak that affected 15 residents and 7 staff members who experienced symptoms such as nausea, vomiting, and diarrhea since 10/28/2024. Findings: 1. During a review of the facility's entrance on 11/14/2024 at 11:00 AM, a total of 4 signages were observed. The signages indicated the following: -Please use mask and use hand sanitizer during flu season October 2024- March 2025 -Attention All Visitors we are currently experiencing an outbreak; please put a mask on prior to entering the facility; speak with an LVN or RN Prior to entering any patient room for further infection control precautions; these precautions are for your safety ass well as the safety of your love ones; thank you. - Stop (Picture of Stop sign) - All Visitors; due to a stomach bug outbreak PLEASE WEAR A MASK AND WASH HANDS AT ALL TIMES During a concurrent observation and interview in the kitchen on 11/14/2024 at 11:04 AM, KA was observed pouring juice from a pitcher to individual cups, and then covering the cups with saran wrap. KA was observed not wearing gloves. KA stated she did not realize she was not wearing gloves. During an interview with the Dietary Supervisor (DS) on 11/14/2024 at 11:06 AM, DS stated kitchen staff were instructed by Public Health to use disposable gloves when preparing and handling food for the patients affected by the outbreak. DS stated kitchen staff was informed that only disposable plates and utensils were to be used for the residents. DS stated kitchen staff should practice safety in wearing gloves when handling ready to eat foods and should wash their hands frequently at the end of the task. During an observation in the facility hallway on 11/14/2024 at 12:01 PM, FM 2 was observed walking to the dining room without wearing a mask. Multiple facility staff did not stop FM 2 as she walked from the facility entrance to dining/activity room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 24's Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 24 was admitted to the facility on [DATE], with diagnoses that included atherosclerosis of aorta (also known as coronary artery disease, condition characterized by the buildup of plaque, consisting of fat, cholesterol, calcium, other subastances on the inner walls of the aorta), bilateral primary osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down) of knee, and Type 2 Diabetes Mellitus (a disorder characterized by difficulty in blood sugar control and poo wound healing). During a review of Resident 24's History and Physical dated 2/6/2024 indicated Resident 24 had the capacity to understand and make decisions. During a review of Resident 24's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 8/9/2024, indicated the resident was cognitively (mentally) intact. The MDS indicated resident required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with sit to stand position, chair/bed-to-chair transfer, and walking more than 10 feet. During a concurrent observation and interview on 11/14/2024 at 12:04 PM, CNA 6 was observed wheeling Resident 24 from the dining room to Resident 24 ' s room. CNA 6 was observed touching resident ' s wheelchair and food tray cover to assist resident for lunch. CNA 6 did not wash hands with soap and water, CNA 6 did not assist Resident 24 to wash resident ' s hands with soap and water. CNA 6 stated she used hand sanitizer for herself and walked out of the room. During an interview on 11/14/2024 at 12:45 PM, CNA 6 stated she used hand sanitizer for hand hygiene and did not help Resident 24 wash her hands prior to eating lunch. CNA 6 stated it was important to wash hands with soap and water during the gastrointestinal outbreak, to prevent infection. CNA 6 stated hand sanitizer was used for hand hygiene if she was really busy. During a review of Resident 2's Face Sheet indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included chronic kidney disease stage 3, type 2 Diabetes Mellitus, and anemia (condition that develops when blood produces a lower-than normal amount of healthy red blood cells). During a review of Resident 2's History and Physical dated 5/20/2024 indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 8/26/2024, indicated the resident had severely impaired cognition. The MDS indicated resident was dependent with sit to stand position, chair/bed-to-chair transfer, and walking more than 10 feet. During a review of Resident 2's Order Summary Report, the physician prescribed an order on 11/5/2024 for Contact isolation precaution every shift for colonized clostridium difficile (C-Diff, very contagious bacterial infection that causes symptoms such as frequent watery diarrhea, abnormal cramping, nausea) for 60 days. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/14/2024 at 12:30 PM, CNA 7 was observed bringing food tray into Resident (PPE)2 ' s room who was under contact isolation. CNA 7 did not don personal protective equipment prior to entering resident ' s room. CNA 7 was observed removing the cover of Resident 2 ' s food tray which had resident ' s lunch in disposable plates and utensils. CNA 7 observed exiting Resident 2 ' s room and proceeded to touch food cart to get another resident ' s tray for lunch. CNA 7 did not perform hand hygiene during entire observation. During an observation on 11/14/2024 at 12:58 PM, prior to entering Resident 2 ' s room was signage that indicated Contact Isolation, MUST PHYSICALLY WASH HANDS. During an interview on 11/14/2024 at 1:12 PM, CNA 7 stated was from registry and was not aware of the gastrointestinal outbreak. CNA 7 stated when he arrived at facility this morning he was given his assignment and was not told about hand washing or instructed about the facility ' s outbreak. During an interview on 11/14/2024 at 1:40 PM, the infection prevention nurse (IPN) stated it was important to wash hands with soap and water during GI outbreak for infection control. IPN stated staff should wash their hands with soap and water and wear PPE if they are going into a contact isolation room. During a review of Resident 6's Face Sheet indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included atherosclerotic heart disease of native coronary artery (coronary artery disease), paroxysmal atrial fibrillation (a fast, irregular heartbeat that lasts a few hours or days), and type 2 Diabetes Mellitus. During a review of Resident 2's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 8/26/2024, indicated the resident was cognitively intact. The MDS indicated resident required partial/moderate assistance with sit to stand position and chair/bed-to-chair transfer. During a concurrent observation and interview on 11/14/2024 at 12:37 PM, AS was observed carrying Resident 6 ' s walker from the dining room and into Resident 6 ' s room. AS left resident ' s room and proceeded to touch chairs in the resident dining/activity room. AS did not perform hand hygiene during this entire observation. AS stated she brought the walker to resident ' s room and forgot to wash her hands. AS stated she should wash her hands every time she is in contact with resident belongings. AS stated the importance of hand washing is for infection control. During a review of Public Health's Gastrointestinal Outbreak Notification Letter dated 10/31/2024, the letter indicated the following recommendation to enforce strict hand washing procedures for all residents and staff, especially washing hands with warm water and soap before meals and after visiting the toilet. During a review of the facility's policy and procedure (P&P) titled Infection Prevention and Control Program, dated 10/24/2022 indicated the facility establishes and maintains an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and State requirements. 46779 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 16's Admission Record indicated the facility originally admitted Resident 16 on 10/2/2023 and readmitted on [DATE] with diagnoses that included mood disorder (a mental health condition that primarily affects your emotional state) and urinary tract infection (an infection in any part of your urinary system [the body system eliminate waste from the body]). During a review of Resident 16's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/24/2024, indicated Resident 16 had severely impaired cognitive (ability to think and reason) skills for daily decision making. During an observation on 11/1/2024 at 1:26 PM, in Resident 16's room, HK 1 was holding a dry dust mop and sweeping the floor with both her gloved hands. Then, HK 1 held Resident 16's bed control remote, which was hung on the bed rail, and pressed the remote with her gloved left hand to elevate the bed to clean the floor underneath the bed. After sweeping the floor underneath the bed, HK 1 pressed the remote to lower the bed to low position, then, she hung the remote on the bed rail. HK 1 continue to sweep the rest of the floor in the room. During an observation on 11/1/2024 at 1:31 PM, in Resident 16's room, HK 1 was holding a wet mop to mop the floor without changing her gloves that she used to sweep the floor with the dry dust mop. HK 1 held Resident 16's bed control remote and pressed the remote with her gloved left hand to elevate the bed to mop the floor underneath the bed. After mopping the floor underneath the bed, HK 1 pressed the remote to lower the bed to low position, then, she hung the remote on the bed rail. HK 1 continue to mop the rest of the floor in the room and the floor in Resident 16's restroom. During an observation on 11/1/2024 at 1:35 PM, in Resident 16's room, HK 1 pulled the floor mat which was next to Resident 16's bed to the other side of the room, then, she cleaned and disinfected the floor mat with both her gloved hands, but she had not changed the gloves since she swept the floor. During an observation on 11/1/2024 at 1:36 PM, in Resident 16's room, HK 1 put the floor mat next to Resident 16's bed after cleaning and disinfecting it with both gloved hands, then, she pushed Resident 16's bedside table next to Resident 16's bed with her right gloved hand without changing gloves. Next, HK 1 removed the gloves and the gown, and threw in the trash bin inside the room, then, she exited the room. During an interview on 11/1/2024 at 1:37 PM, with HK 1, HK 1 stated she did not change gloves in between the tasks of sweeping and mopping the floor, touching the bed control remote, cleaning and disinfecting the floor mat, and touching the bedside table. HK 1 stated she only clean and disinfect the bed control remote and beside table at the beginning of cleaning the room, but she did not clean and disinfect the bed control remote and the bedside table after she sweeping and mopping the floor, and cleaning and disinfecting the floor mat. During an interview on 11/1/2024 at 06:30 PM, with the Director of Nursing (DON), the DON stated the gloves were dirty during the process of sweeping and mopping the floor and cleaning and disinfecting the floor mat. The DON stated HK should change gloves before touching the clean items and disinfect the bed control remote and bedside table before exiting. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

3. During a review of Resident 7's Admission Record indicated the facility originally admitted Resident 7 on 7/24/2023 and readmitted on [DATE] with diagnoses that included dementia (A group of thinking and social symptoms that interferes with daily functioning) and heart failure (a serious condition that occurs when the heart is unable to pump enough blood and oxygen to the body).

During a review of Resident 7's MDS, dated [DATE], indicated Resident 7 had severely impaired memory and cognition. The MDS indicated Resident 7 required setup or clean-up assistance with eating and oral hygiene, partial/moderate assistance with toileting hygiene, personal hygiene, and chair/bed-to-chair transfer, and substantial/maximal assistance with shower/bathe self.

During a review of Resident 19's Admission Record indicated the facility originally admitted Resident 7 on 3/8/2021 and readmitted on [DATE] with diagnoses that included dementia (A group of thinking and social symptoms that interferes with daily functioning) and hyperlipidemia (a condition where there are high levels of fat in the blood).

During a review of Resident 19's MDS, dated [DATE], indicated Resident 19 had moderately impaired memory and cognition.

During an observation on 11/1/2024 at 5:32 PM, the Contact Precautions (a set of steps to prevent the spread of infectious diseases through direct or indirect contact with a patient or their environment) signage was posted by the door of Resident 7's room, indicating everyone must put on gloves and gown before room entry for Resident 7. Resident 7 was sitting at her bedside table with her completed dinner tray on the table in the room. Certified Nursing assistant (CNA) 4 put on a pair of new gloves and went into Resident 7's room without putting on a gown, then, she picked up Resident 7's dinner tray and put the tray on the food delivery cart. CNA 4 sanitized her hands with the alcohol sanitizer, then, she went in Resident 19's room and pick up Resident 19's dinner tray from the bedside table and put it to the food delivery cart.

During an interview on 11/1/2024 at 5:34 PM, with CNA 4, CNA 4 stated she knew that Resident 7 was on contact isolation, and she should put on a gown when providing care Resident 7. CNA 4 stated she did not put on a gown when picking up Resident 7's tray because she did not realize that her other parts of body and clothing could contract bacteria and virus and pass the infection to other residents.

During an interview on 11/1/2024 at 6:31 PM, with the DON, the DON stated contact precautions must be followed when providing care to the infected resident, including wearing personal protective equipment (PPE).

4. During a review of Resident 14 's Admission Record indicated the facility admitted Resident 14 on 2/9/2024 with diagnoses that included dementia and hyperlipidemia.

During a review of Resident 14's MDS, dated [DATE], indicated Resident 14 had moderately impaired memory and cognition. The MDS indicated Resident 14 was independent with eating, personal hygiene, and chair/bed-to-chair transfer, and required partial/moderate assistance with shower/bathe self.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an observation on 11/1/2024 at 5:38 PM, the Contact Precautions signage was posted by the door of Resident 14's room, indicating everyone must put on gloves and gown before room entry for Resident 14. In Resident 14's room, Resident's family member (FM) 1 was wearing a pair of gloves and a mask, but she was not wearing a gown. FM 1 was touching and arranging Resident 14's bed linens that were on Resident 14's bed.

During an interview on 11/1/2024 at 5:40 PM, with FM 1, FM 1 stated when she came in the facility to visit Resident 14, no staff stopped her and told her to put on a gown before she entered Resident 14's room. FM 1 stated she did not pay attention to the Contact Precautions signage posted by the door of Resident 14's room. FM 1 stated she did not know the facility was having an outbreak and Resident 14 was infected in this outbreak.

During a concurrent observation and interview on 11/1/2024 at 5:45 PM, with the Administrator (ADM), a signage was posted on the wall above the visitor's sign-in table, indicated due to a stomach bug outbreak, all visitors need to wear a mask and wash hands at all times. FM 1 was visiting Resident 14 without wearing a gown. The ADM stated the signage, that only informing the visitors to wear a mask and wash hands, did not provide the proper protection guidance for the visitors. ADM stated a proper signage for the visitor would be posted to be compliance with the contact precautions during the outbreak. The ADM stated when the visitor, who was visiting the infected resident, must follow the contact precautions to put on gloves and a gown before entering the room. The ADM stated the staff should inform and educate the visitors the importance of putting on proper PPEs to protect themselves and the residents in the facility.

5. During a record review of the Facsimile Transmittal Sheet, dated 10/31/2024, indicated the facility reported the gastrointestinal (GI, the body system that takes in food and liquids and break them down into substances that the body can use for energy, growth, and repair) outbreak in the facility on 10/31/2024 at 2:25 PM.

During an interview on 11/1/2024 at 4:25 PM, with the DON, the DON stated two residents exhibited the GI symptoms, such as nausea, vomiting and diarrhea on 10/28/2024 nighttime, but she thought the two symptomatic resident were isolated cases when she came in to work on 10/29/2024. The DON stated two more residents reported similar GI symptoms on 10/29/2024 nighttime. The DON stated when she returned to work on 10/30/2024 morning and was informed about two more symptomatic residents, she started to link these four residents together and suspected a GI outbreak. The DON stated she reported to Los Angeles County Department of Public Health (LAC DPH) and spoke to a doctor from LAC DPH on 10/30/2024. The DON stated the LAC DPH doctor suspected Norovirus (a group of viruses that causes severe vomiting and diarrhea. It's a very common illness and it's very contagious) might be the cause of the outbreak and provided her with the guidance.

During a concurrent interview and record review on 11/1/2024 at 4:27 PM, with the DON, Norovirus (Viral Gastroenteritis) Control Measures for Skilled Nursing Facilities, dated 12/1/2006, was reviewed. The DON stated according to the guidance, the facility should notify LAC Public Health and LAC Health facilities. The DON stated she did not report to LAC Health Facilities on 10/30/2024 because the phone number that listed on the guidance for LAC Health Facilities was not a working number.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 11/4/2024 at 12:20 PM, with the ADM, the facility's Policy and Procedure (P&P) titled, Unusual Occurrence Reporting, dated 10/1/2017, was reviewed. The ADM stated they had the LAC Health Facilities phone number in the nursing station and the DON should have reported the outbreak to the LAC Health Facilities on 10/30/2024. The ADM stated he did not know the cases were reportable cases to LAC Health Facilities until the Public Health Nurse informed him to report to LAC Health Facilities on 10/31/2024, then, he faxed the report to LAC Health Facilities on 10/31/2024. The ADM stated according to the facility's P&P, the facility should report the unusual occurrences to the appropriate agency within 24 hours, but the reporting of the outbreak to the LAC Health Facilities was delayed this time. During a review of the facility's P&P titled, Norovirus (Viral Gastroenteritis) Control Measures for Skilled Nursing Facilities, dated 12/1/2006, indicated notify LAC Public Health at . and LAC Health Facilities at . The P&P indicated the facility should increase frequency of routine ward cleaning and give special attention to frequently touched objects. The P&P also indicated Educate staff, residents and visitors about methods of transmission. Wear Gloves, gown, and surgical or procedural mask when in contact with a symptomatic resident. Remove protective equipment and wash hands after contact with an ill resident and before contact with an unaffected resident. During a review of the facility's P&P titled, Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings, dated 2/15/2017, indicated the facility ensure that the visitors comply with hand hygiene and Contact Precautions. During a review of the facility's P&P titled, Unusual Occurrence Reporting, dated 10/1/2017, indicated Unusual occurrences are reported to the appropriate agency within 24 hours by telephone and then confirmed in writing. During a review of the facility's P&P titled, Personal Protective Equipment, dated 4/28/2020, indicated staff wear gloves whenever there is touching blood, body fluids, secretions, excretions, mucous membranes, and/or non-intact skin, and gloves are used only once and are discarded into the appropriate located in the room in which the procedure is being performed. During a review of the facility's P&P titled, Reportable Diseases, dated 12/1/2021, indicated the facility to ensure the timely reporting of disease as required to the appropriate officials. During a review of the facility's P&P titled, Visitation-Infection Control, dated 10/10/2022, indicated the facility will post a notice to visitors related to limitations or restrictions on visitation at each entrance. The P&P indicated visitors must follow instruction regarding Facility infection control practices and visitation restrictions, which includes donning and doffing of PPE. During a review of the facility's P&P titled, Resident Isolation-Categories of Transmission-based Precautions, dated 10/24/2022, indicated PPE are required, including gloves and gowns, to care for residents who are placed under Contact Precautions. 50203 6. During a review of Resident 20's Admission Records (Face sheet), the facility admitted Resident 20 on 2/10/2020 and readmitted her on 8/18/2022 with diagnoses of, but not limited to, a broken left leg and hemiplegia (paralysis) of the left side. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 20's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/19/2024, Resident 20 was severely cognitively (mental process involved in knowing, learning, and understanding) impaired. During a review of Resident 20's History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 9/3/2024, Resident 20 does not have the capacity to understand and make decisions. During a review of Resident 6's Admission Records (Face sheet), the facility admitted Resident 6 on 10/11/2024 with diagnoses of, but not limited to, a broken right leg and atherosclerotic heart disease (build-up of fats or cholesterol in the arteries [tublike structures transporting blood from the heart of the rest of the body]). During a review of Resident 6's H&P, dated 10/12/2024, Resident 6 does not have the capacity to understand and make decisions. During a review of Resident 6's MDS, dated [DATE], Resident 6 was cognitively intact. During a review of the Sample Case Log of Resident and Staff with Acute Gastrointestinal Illness, received on 11/1/2024, Resident 6 ' s started to experienced nausea and vomiting on 10/29/2024. During an observation on 11/1/2024 at 1PM, a Contact Precaution isolation sign (isolation sign posted by an isolation room that required staff and visitors to wear a gown and gloves) was posted by Resident Room (RR) 1 with Resident 6 ' s bed number written on it. Certified Nurse Assistant (CNA) 1 was observed inside the room wearing personal protective equipment (PPE, specialized equipment such as gown, gloves, and mask that minimize exposure to hazards that may cause illness) and seated next to Resident 20 ' s bed. During an observation on 11/1/2024 at 1:10PM, CNA 1 walked out of RR 1 wearing her PPE and holding a food tray. CNA 1 walked down the hallway to the kitchen and dropped off the food tray. During an interview on 11/1/2024 at 1:14PM with CNA 1, CNA 1 stated, she was helping Resident 20 with her lunch but wore her PPE just in case Resident 6 needed help. CNA 1 stated, she should have removed her PPE before leaving the room for infection control and to not spread germs. 7. During a review of Resident 8's Face sheet, the facility admitted Resident 8 on 12/01/2022 and readmitted Resident 8 on 7/19/2024 with diagnoses of, but not limited to, atherosclerotic heart disease and urinary tract infection (UTI, an infection in the bladder/urinary tract). During a review of Resident 8's H&P, dated 7/20/2024, Resident 8 does not have the capacity to understand and make decisions. During a review of Resident 8's MDS, dated [DATE], Resident 8 was severely cognitively impaired. During a review of the Sampled Case Log of Resident ad Staff with Acute Gastrointestinal Illness, received on 11/1/2024, Resident 8 started to experience nausea and vomiting on 10/30/2024. (continued on next page)

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 11/14/2024
NAME OF PROVIDER OR SUPPLIER Ararat Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 2373 Colorado Blvd. Los Angeles, CA 90041	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's Face sheet, the facility admitted Resident 3 on 8/13/2021 with diagnoses of, but not limited to, hemiplegia of the left side and dementia (loss of cognitive function that interferes with a person ' s daily life and activities). During a review of Resident 3's H&P, dated 9/3/2024, Resident does not have the capacity to understand and make decisions. During a review of Resident 3's MDS, dated [DATE], Resident 3 was severely cognitively impaired. During an observation on 11/1/2024 at 1PM, a Contact Precaution isolation sign was posted by RR 2 with Resident 8 ' s bed number written on it. During an observation on 11/1/2024 at 1:27PM, CNA 2 was in RR 2 talking with Resident 8. CNA 2 walked out of RR 2 and walked into RR 3 to talk to Resident 3 without using the hand sanitizer. During an interview on 11/1/2024 at 1:30PM with CNA 2, CNA 2 stated, he did not use the alcohol-based hand rub before entering or leaving a resident room. CNA 2 stated, he should have used alcohol-based hand rub or wash his hands before any contact with the resident, changing resident ' s undergarments, assisting with feeding the resident, and going in between two residents. During an interview on 11/1/2024 at 3:55PM with the Infection Preventionist (IP), the IP stated, the staff members should wash their hands or use alcohol-based hand rub before and after caring for the residents. The IP stated, it was important to stop the spread of virus or infection to other residents and staff members. During an interview on 11/1/2024 at 6:30PM with the Director of Nursing (DON), the DON stated, CNA 1 should have not worn the PPE in the hallway. The DON stated, CNA 1 ' s PPE could have spread the virus or the bacteria to other residents, visitors, or staff members in the hallway. The DON stated, it was important for staff members to wash their hands with soap and water or use alcohol-based hand rub in between resident cares to stop the spread of infection. During a review of the facility policies and procedures (P&P) titled Personal Protective Equipment, dated 4/28/2024, indicated if the gown was used, it should be used once and thrown away in the same room it was used in. During a review of the facility ' s P&P titled Resident Isolation - Categories of Transmission-Based Precautions, dated 10/28/2022, indicated the gown should be removed and hand hygiene should be performed before leaving the resident ' s environment. During a review of the facility ' s P&P titled Hand Hygiene, dated 6/1/2017, indicated that the facility staff followed the hand hygiene procedures to help prevent the spread of infection to other staff, residents, and visitors. The P&P indicated that facility staff, visitors, and volunteers must perform hand hygiene procedures such using alcohol-based hand hygiene products immediately upon entering or exiting a resident occupied area.