

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 11/15/2024
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 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219</p> <p>During an observation, interview and record reviews, the facility failed to ensure one of three sampled residents (Resident 1) was free from the use of physical restraints (a manual method or device that limits a person's ability to move freely), in accordance with the facility ' s policy and procedure titled Restraints by failing to:</p> <ol style="list-style-type: none"> 1. Identify a situation that constitutes abuse when Certified Nurse Assistant [CNA] 1 had knowledge that Resident 1 was tied to the wheelchair with a white sheet, on 11/9/24, during the 3 PM to 11 PM shift, as evidenced by a videoclip . CNA 1 did not untie (remove) the white sheet from Resident 1 and did not report the observation to the licensed vocational nurse (LVN 1) immediately. 2. Protect Resident 1 from potential harm that could result in an injury by not responding immediately to protect Resident 1 when CNA 1 witnessed Resident 1 tied up with a white sheet to the wheelchair on 11/9/24. Instead, CNA 1 recorded a video of Resident 1 while tied up with a white sheet to the wheelchair, inside another resident ' s [Resident 2] room. 3. Report all alleged violations of abuse immediately to the abuse coordinator [Administrator] and other State Agencies immediately or within two hours when CNA 1 had knowledge of Resident 1 being restrained with a white sheet on 11/9/2024. CNA 1 did not inform the abuse coordinator [Administrator] of witnessing Resident 1 tied up to the wheelchair on 11/9/2024. <p>These failures resulted in Resident 1 experiencing abuse and had the potential to result in serious injury that included strangulation [occurs when something compresses the neck tightly enough to restrict airflow], accidental asphyxiation [compression of the chest wall] to Resident 1, who was cognitively impaired [difficulties with thinking, learning, remembering, and making decisions] and unable to verbalize needs.</p> <p>On 11/13/2024 at 9:30 AM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider ' s noncompliance [not following rules] with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding the facility ' s failure to ensure Resident 1 was free from restraints. The surveyor notified the Administrator and the Director of Nursing (DON) of the IJ situation on 11/13/2024 at 9:30 AM, due to the facility ' s failure to protect Resident 1 and identify a situation that constitutes abuse when CNA 1 witnessed the improper use of physical Restraints against Resident 1.</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 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 11/15/2024 at 1:53 PM, while onsite and after the surveyor verified/confirmed the facility ' s full implementation of the IJ Removal Plan (a detailed plan to address the IJ findings) through observation, interview, and record review, and determined the IJ situation was no longer present, the IJ was removed onsite, in the presence of the Administrator.</p> <p>The acceptable IJ Removal Plan included the following information:</p> <ol style="list-style-type: none"> Starting 11/14/2024, staff including but not limited to license nurses, certified nursing assistants, office staff, kitchen staff, and housekeeping staff will have in-service education regarding elder abuse, reporting abuse and the use of physical restraints, conducted by the Director of Staff Development [DSD], DON and /or Administrator. The in-services are based on facility Policies and Procedures titled Restraints, Abuse Prevention and Prohibition Program, and Definitions. By 11/18/2024, 50 out of 61 facility employees will have received in-service education regarding elder abuse, reporting abuse and the use of physical restraints. A posttest was created to verify staff competency on abuse and use of restraints. The post test will be given to all staff to determine understanding of in-service. Staff will be given repeat in-service on areas found to be lacking in knowledge until 100% score is received. Starting 11/12/2024, charge nurses were assigned to complete Abuse Rounds on a minimum once per shift to ensure there are no signs or symptoms of abuse or restraints. Rounds will continue once per shift for a minimum of three months. If a suspected abuse or improper restraint is identified charge nurse will immediately notify the Administrator and DON. On 11/15/2024 at 2:30 PM, the facility ' s Social Services Consultant will provide staff in-service regarding abuse. All charge nurses will be in-serviced on use of SOC 341 [a form used to report suspected abuse or neglect of dependent adults and elders] starting 11/14/2024 By 11/19/2024, the Administrator will review facility ' s current Abuse Prevention Plan with DSD to develop a new yearly in-service schedule with increased abuse training. New employee Orientation abuse and neglect training will be reviewed and updated as needed during the facility ' s Quality Assurance and Performance Improvement (QAPI) [is a data driven and proactive approach to quality improvement] on 11/19/2024. <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, [AR] the AR indicated the facility admitted the resident on 12/20/2018 and readmitted on [DATE], with a primary diagnosis of dementia (loss of ability to think, remember and reason), anxiety disorder [an emotion characterized by feeling of worried thoughts and tension] and history of falling.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s care plan revised on 1/3/2024, the care plan indicated Resident 1 was a Wandering/Elopement [leaving without permission] Risk as evidenced by attempts to leave the facility unattended, wanders aimlessly, and had impaired safety awareness. The care plan interventions included to allow Resident 1 to wander in safe surroundings within the facility, and to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. The care plan interventions further indicated to monitor Resident 1 ' s whereabouts with visual checks at least every two hours for safety.</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/11/2024, the MDS indicated the resident had severely impaired cognition (thought process). The MDS indicated Resident 1 exhibited wandering behavior daily.</p> <p>During a review of Resident 1 ' s Multidisciplinary Care Conference (ID- Interdisciplinary Team) dated 9/6/2024, the IDT indicated the resident was confused and disoriented with a history of dementia and to keep resident safe and comfortable by offering a physical and social environment that provides activities appropriate for the resident ' s cognitive functioning and interests. The care plan interventions further indicated to reassure the resident that she was safe in the facility, loved and wanted.</p> <p>During a review of Resident 1 ' s Wandering Risk Assessment (a tool to identify residents who are at risk of wandering dated 9/11/2024, the Assessment indicated Resident 1 was disoriented and does not understand surroundings. The Assessment indicated Resident 1 was a known wanderer with a history of wandering.</p> <p>During a concurrent observation and interview with Resident 1 on 11/13/2024 at 9:57 AM, at the facility ' s Dining Room, Resident 1 was observed walking steadily. Resident 1 stated she did not recall anything and could not remember being tied with a white sheet to the wheelchair.</p> <p>During a telephone interview with CNA 1 on 11/13/2024 at 10:29 AM, CNA 1 stated on 11/9/2024, at around dinner time (8 PM), during the 3 PM to 11 PM shift, CNA 1 found Resident 1 inside another resident ' s [Resident 2] room and witnessed Resident 1 tied up with a white sheet to the wheelchair which was tied at the back with a knot. CNA 1 further stated that she recorded a videoclip of the incident [Resident 1 while tied up to the wheelchair]. CNA 1 stated Resident 1 appeared scared at the time. CNA 1 stated that on 11/9/2024, CNA 1 had called the Administrator on the phone from the facility ' s parking lot after witnessing Resident 1 tied up to the wheelchair. CNA 1 stated when she returned from the parking lot, CNA 1 stated someone had removed the sheet from Resident 1. CNA 1 stated, she did not inform the Administrator about what she had witnessed, Resident 1 tied up with a white sheet to the wheelchair. CNA1 stated she did not notify the Charge Nurse or any of the facility staff on duty that evening [11/9/2024] about witnessing Resident 1 tied up with a white sheet to the wheelchair. CNA 1 stated it was not until the following Monday, on 11/11/2024, when she informed the Administrator, in person, that she witnessed Resident 1 tied up with a white sheet to the wheelchair on 11/9/2024. CNA 1 stated that she informed the Administrator of taking a videoclip while Resident 1 was tied up.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 11/13/2024, at 10:58 AM, during a review of the videoclip shared via instant messaging [iMessage - a communication technique that facilitates text-based communication to include multimedia content such as photos, videos, and audio recording] by CNA 1, the videoclip showed Resident 1 sitting on a wheelchair inside a room, in front of the television, with a white sheet around the resident with a knot tied to the back of the wheelchair. The recorder [CNA1] continued going around Resident 1 showing a full 360-degree angle [a view in every direction] of Resident 1 tied down with a white sheet while sitting on the wheelchair. The part of the videoclip recording at 00:28 [timecode] mark, showed an individual (unknown) pushing Resident 1 ' s hands away from the resident ' s chest showing full view of the white sheet tied across the resident ' s chest.</p> <p>During another telephone interview on 11/13/2024 at 11:15 AM with CNA 1, CNA 1 stated the time she witnessed Resident 1 with a white sheet tied to the back of the wheelchair on 11/9/2024, was around 8 PM. CNA 1 stated she saw Resident 1 inside another resident ' s [Resident 2] room sitting on a wheelchair with a white sheet wrapped around Residents 1 ' s abdomen/chest area tied in a knot at the back of the wheelchair. CNA 1 stated she recorded a video of Resident 1 tied up, as proof to show the Administrator of the alleged abuse. CNA 1 stated after recording a video of Resident 1 she did not report it to the charge nurses or LVN 1 or any facility staff in the facility because CNA 1 was afraid, they [other facility staff] would untie Resident 1 and deny ever tying her.</p> <p>During the same interview, on 11/13/2024 at 11:15 AM, CNA 1 stated she stepped out of the facility to go to the facility ' s parking lot to call the Administrator on 11/9/2024, because she knew to report any type of abuse she witnessed to the facility's Administrator. CNA 1 stated she spoke to the Administrator over the phone and informed the Administrator that he had to come to the facility right away, to see with his own eyes what was happening to Resident 1. CNA 1 further stated she did not tell the Administrator what she observed, and told the Administrator, It was an urgent matter concerning Resident 1 and that he had to come in person to the facility to witness with his own eyes. CNA 1 stated the Administrator informed her [CNA 1], that he would talk to CNA 1 on Monday [11/11/2024]. CNA 1 stated after ending the phone conversation, CNA 1 sent another text message to the Administrator asking him to come to the facility because it was something very important and wanted the Administrator to see with his own eyes. CNA 1 stated the Administrator did not respond to her text message. CNA 1 stated that when she went back inside the facility to check on Resident 1, CNA 1 observed Resident 1 was back in her room lying in bed. CNA 1 stated she did not know who from the facility had untied and returned Resident 1 back to her room.</p> <p>During an interview with the DON on 11/13/2024 at 11:30 AM, the DON stated she was not aware of Resident 1 being tied to the wheelchair until 11/11/2024. The DON stated the Administrator had called her on 11/9/2024 and informed her that there was a CNA incident [the phone call that the Administrator received from CNA 1] that happened at the facility, and that the Administrator and the DON would follow up the following Monday, on 11/11/2024. The DON stated, on 11/11/2024, the Administrator and the DON met with CNA 1 to discuss what CNA 1 wanted to discuss on 11/9/2024. The DON stated CNA 1 informed both the Administrator and the DON about witnessing Resident 1 tied up to the wheelchair on 11/9/2024 and briefly shared the videoclip of Resident 1 during that evening. The DON stated when CNA 1 was asked why she had not reported the abuse incident earlier, on 11/9/2024, CNA 1 stated that she preferred to report Resident 1 ' s incident [abuse] in person. The DON stated there was a delay of three days when CNA 1 decided to report witnessing Resident 1 tied up to the wheelchair on 11/11/2024.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview with the Administrator on 11/13/2024, at 11:45 AM, the Administrator stated he received a text message from CNA 1 on 11/9/2024 at around 5 PM informing him that CNA 1 had proof of something very important. The Administrator stated that at 6:22 PM, CNA 1 texted him again stating this was not about CNA 1 but about a resident [did not indicate a specific resident 's name]. Administrator stated he called CNA1 back at around 6:24 PM and asked about her concerns in the text message. The Administrator stated that CNA1 informed him, there was no emergency, and the issue was not urgent and stated CNA 1 would discuss the situation to the Administrator that following Monday, 11/11/2024. The Administrator stated he called the DON to inform her of the CNA 1 ' s phone call and that they would talk to CNA 1 on Monday [11/11/24].</p> <p>During the same interview with the Administrator on 11/13/2024 at 11:45 AM, the Administrator stated on 11/11/2024 at 3:13 PM, CNA 1 came to his office and showed the DON and himself, the videoclip of the incident [being tied up to the wheelchair] involving Resident 1. The Administrator stated he informed CNA 1 that the videoclip CNA 1 showed was abuse and should have been reported by CNA 1 immediately to the proper authorities [abuse coordinator and other State Agencies] as soon as it was witnessed in accordance with the facility ' s policy and procedure [P&P].</p> <p>During a concurrent interview on 11/13/2024 at 2:15 PM with the Administrator, the Administrator stated he had started an investigation on 11/11/2024 regarding Resident 1 ' s abuse incident on 11/9/2024, that was reported to the Administrator on 11/11/2024 by CNA 1. The Administrator stated he had place CNA 1 on suspension (temporarily removed from their job duties, usually while an investigation is underway) on 11/11/2024, but had not suspended CNA 2 who was the assigned CNA for Resident 1 during the 3 PM to 11 PM shift, on 11/9/2024 (4 days after the abuse incident). The Administrator stated that he did not suspend CNA 2 right away because CNA 2 was not scheduled to work until Thursday, 11/14/2024.</p> <p>During an interview with LVN 1 on 11/14/2024 at 1:15 PM, LVN 1 stated she was working on a Saturday, dated 11/9/2024, during the 3 PM to 11 PM shift, as a Charge Nurse. LVN 1 stated no one had come forward to report seeing any resident in a sheet restraint. LVN 1 stated, the Administrator called her at the facility on 11/9/2024 and gave her instructions to make rounds to ensure the safety of the residents. LVN 1 stated, she had asked CNA 1 if there were any issues she wanted to discuss or report on 11/9/2024, but CNA1 stated it was not an emergency and refused to discuss the matter with LVN 1.</p> <p>During a review of the facility ' s P&P titled Restraints revised on 11/1/2017, the P&P indicated residents shall be provided an environment that is restraint- free, unless a restraint is necessary to treat a medical symptom in which case the least restrictive measures shall be used.</p> <p>During a review of the facility ' s P&P titled Abuse Prevention and Prohibition Program revised on 10/24/2022, the P&P indicated each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion. Anyone who suspects that an abuse has been committed against a resident must immediately report this information to the Administrator and to the Director of Nursing Services. The P&P indicated it is the Administrator ' s responsibility to ensure the proper authorities and individuals are notified immediately or within two hours.</p>		