

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555579	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/21/2025
NAME OF PROVIDER OR SUPPLIER  Ararat Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE  15099 Mission Hills Road Mission Hills, CA 91345	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878</b></p> <p>Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) and verbal abuse (the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or to their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability) for two of six sampled residents (Resident 1 and Resident 3) when:</p> <p>1. On 5/9/2025 at 1:30 p.m., Resident 1 and Resident 2, who were both inside Room A (Resident 1 and Resident 2's shared room), were observed by Certified Nursing Assistant (CNA) 1, when Resident 2 made a fist with his left hand and punched Resident 1 on Resident 1's lower right abdomen, then Resident 2 used verbal profanity towards Resident 1.</p> <p>This deficient practice resulted in Resident 1 being subjected to physical and verbal abuse by Resident 2 while under the care of the facility.</p> <p>2. On 5/9/2025 during lunch time, Resident 3 and Resident 4, who were sitting at the same table in the Staff Dining (SD) room, were observed by Activities Staff (AS ) 1 and AS 2 having a verbal argument. Resident 3 and Resident 4 both stood up and walked to the end of the table where Resident 4 was observed using his left open hand to push Resident 3 on Resident 3's shoulder.</p> <p>This deficient practice resulted in Resident 3 being subjected to physical abuse by Resident 4 while under the care of the facility.</p> <p>Findings:</p> <p>a. During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 4/10/2025 with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), unspecified psychosis (when someone experiences a loss of contact with reality, often marked by hallucinations [seeing or hearing things that aren't there] and delusions [false beliefs]), and unspecified dementia (a progressive state of decline in mental abilities).</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/17/2025, the MDS indicated Resident 1's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 1 required substantial to maximal assistance (helper does more than half the effort) with showering and required partial to moderate assistance (helper does less than half the effort) with toileting, upper and lower body dressing and putting on and taking off footwear.</p> <p>During a review of the facility-provided record titled, Abuse Investigation Reporting Form, dated 5/14/2025, the Abuse Investigation Reporting Form indicated based on eyewitness accounts from CNA 1, the facility substantiated that Resident 2 made contact with Resident 1 after Resident 1 attempted to wake Resident 2 up with Resident 2 hitting Resident 1 in the stomach.</p> <p>b. During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted Resident 2 on 4/15/2025 with diagnoses of atrial fibrillation (a condition where the upper chambers of the heart [atria] beat irregularly and rapidly, sometimes faster than normal), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and muscle weakness (generalized).</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had the ability to understand and be understood. The MDS indicated Resident 2 required substantial to maximal assistance with toileting, showering, upper and lower body dressing, and putting on and taking off footwear and required partial to moderate assistance with oral hygiene and personal hygiene.</p> <p>During a review of Resident 2's Incident Note, dated 5/9/2025 at 2:41 p.m., the Incident Note indicated at 1:30 p.m. CNA 1 reported that Resident 1 told CNA 1 Resident 1 wanted to see her husband (Resident 2) and CNA 1 told Resident 1 Okay, but come back. CNA 1 stated she decided to follow Resident 1 and that was how CNA 1 saw Resident 2 hit Resident 1 for waking up Resident 2, then Resident 2 called Resident 1 names.</p> <p>During an interview on 5/21/2025 at 10:36 a.m. with Resident 2, Resident 2 stated he cannot recall date of incident but must have occurred more than a week ago. Resident 2 stated he shared a room with wife (Resident 1) and Resident 1 kept waking Resident 2 up and around 1 p.m. Resident 1 woke Resident 2 up again and Resident 2 stated with his left-hand he (Resident 2) shoved or pushed Resident 1 back telling Resident 1 to go away. Resident 2 stated he said some bad words to Resident 1 like you stupid women and may have used profanity (offensive or vulgar language, often considered impolite, rude, or disrespectful).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/21/2025 at 1:07 p.m. with CNA 1, CNA 1 stated recalls incident with Resident 1 and Resident 2 but does not recall the exact date and said it was around 1:30 p.m. after lunch. CNA 1 stated she was doing her charting (documentation) right outside of Room A, Resident 1 and Resident 2's shared room, with Resident 1 by her (CNA 1) side asking about Resident 2. CNA 1 stated she told Resident 1 that Resident 2 was sleeping but Resident 1 wanted to see Resident 2. CNA 1 stated she told Resident 1 she could take a look at Resident 2 but to leave Resident 2 alone. CNA 1 stated she followed Resident 1 into Room A. CNA 1 stated Resident 1 walked into Room A and walked in front of Resident 2 and shrugged Resident 2's shoulder and whispered to Resident 2 trying to wake Resident 2 up. CNA 1 stated Resident 2 was lying on his right side facing away from the door. CNA 1 stated she saw Resident 2 make a fist with his left hand and with the back of his hand Resident 2 punched Resident 1 on her lower abdomen and Resident 1 scooted back and Resident 2 was yelling at Resident 1 in their own language. CNA 1 stated she rushed to Resident 1 and Resident 2's side and told Resident 2 that was not okay, and Resident 2 said profanities toward Resident 1. CNA 1 stated based on what she witnessed it was physical and verbal abuse.</p> <p>c. During a review of Resident 3's Admission Record, the Admission Record indicated the facility admitted Resident 3 on 12/6/2024 with diagnoses including unspecified dementia, psychotic disturbance (when someone experiences a significant disconnect from reality), mood disturbance (someone is experiencing a significant or unusual shift in their emotional state), and anxiety (a feeling of fear, dread, and uneasiness).</p> <p>During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 was able to understand and be understood. The MDS indicated Resident 3 was dependent (helper does all of the effort) with showering, lower body dressing, putting on and taking off footwear, required substantial to maximal assistance with toileting, upper body dressing, and personal hygiene and required partial to moderate assistance with oral hygiene.</p> <p>During a review of Resident 3's Incident Note dated 5/9/205 at 12:59 p.m., the Incident Note indicated Resident 3 received lunch which came with a Boost (doctor recommended oral nutritional supplement) from activities and Resident 4 grabbed Resident 3's Boost from Resident 3's tray. The Note indicated Resident 3 went to retrieve the Boost which angered Resident 4 making Resident 4 swing his left arm and made contact with Resident 3's right side of neck below the ear.</p> <p>During a review the facility-provided record titled, Abuse Investigation Reporting Form, dated 5/13/2025, the Abuse Investigation Reporting Form indicated based on eyewitness accounts the facility substantiated that Resident 4 made contact with Resident 3 on the right side of his body shoulder and neck area below the ear.</p> <p>d. During a review of Resident 4's Admission Record, the Admission Record indicated the facility admitted Resident 4 on 1/6/2023 with diagnoses including major depressive disorder, unspecified dementia, and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities).</p> <p>During a review of Resident 4's MDS, dated [DATE], the MDS indicated that Resident 4 had the ability to understand and be understood. The MDS indicated that Resident 4 required substantial to maximal assistance with showering, and putting on and taking off footwear, and required partial to moderate assistance with toileting, lower body dressing and personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/21/2025 at 10 a.m. with Resident 4, Resident 4 stated the incident with Resident 3 was about a week ago and does not recall exact date, but it was in the morning around 11 a.m. Resident 4 stated was in the SD room sitting at the table with Resident 3. Resident 4 stated Resident 3 wanted Resident 4's Boost.</p> <p>During an interview on 5/21/2025 at 12:09 p.m. with AS 2, AS 2 stated the incident with Resident 3 and Resident 4 occurred on 5/9/2025 around lunch time. AS 2 stated Resident 3 and Resident 4 were sitting at the same table across from each other, both in their wheelchairs. AS 2 stated she was in the SD room far away from Resident 3 and Resident 4 assisting another resident when AS 2 observed Resident 3 stood up. AS 2 stated she ran to Resident 3 because she did not want Resident 3 to fall. AS 2 stated AS 1 was already standing next to Resident 3 when she got to Resident 3. AS 2 stated hearing Resident 3 saying that Resident 4 had taken his (Resident 3) Boost. AS 2 stated that Resident 3 and Resident 4 were both standing up and had moved to the front of the table now directly in front of each other and Resident 4 pushed Resident 3. AS 2 stated Resident 4 with an open hand (AS 2 stated cannot recall which hand Resident 4 used) pushed Resident 3 but because AS 2 and AS 1 were there they (AS 2 and AS 1) prevented Resident 3 from falling.</p> <p>During an interview on 5/21/2025 at 12:34 p.m. with AS 1, AS 1 stated she does not recall date of the incident with Resident 3 and Resident 4, but it was between 11:30 a.m. and 12 p.m. during setting up the tables for lunch. AS 1 stated she was standing next to the table where Resident 3 and Resident 4 were sitting and heard Resident 3 and Resident 4 arguing, and they (Residents 3 and 4) were getting loud. AS 1 stated she heard Resident 3 said to Resident 4, You stole my Boost. AS 1 stated she approached Resident 3 and Resident 4 and that was when they (Residents 3 and 4) both got up and walked to the edge of the table (initially Resident 3 and Resident 4 were sitting across from each other in the same table in their wheelchairs). AS 1 stated she went to Resident 3 to support Resident 3 to avoid a fall, then saw AS 2 come to the other side of Resident 3. AS 1 stated she was standing on the left side of Resident 3 and AS 2 was standing on the right side of Resident 3 when Resident 4 with an opened hand pushed Resident 3, hitting Resident 3's right shoulder with enough force to push Resident 3 to fall back. AS 1 stated Resident 3 is not stable and does not have a good balance. AS 1 stated if AS 1 and AS 2 were not there Resident 3 would have fallen.</p> <p>During an interview on 5/21/2025 at 4:14 p.m. with the Director of Nursing (DON), the DON stated Resident 4 punched Resident 3 around Resident 3's ear and neck area. The DON stated Resident 3 had no injuries but would consider this abuse because Resident 4 knew what he was doing and reacted physically and hit another resident. The DON stated abuse is a concern for the safety of other residents. The DON stated the facility does not allow abuse in the facility. The DON stated there are concerns for failing to provide protection for other residents. The DON stated it can cause death if Resident 4 hit Resident 3 hard enough and Resident 3 fell and hit the head.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Abuse Prevention and Prohibition Program, last revised on 1/2025, the P&amp;P indicated the purpose is To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to . protect residents . in accordance with federal and state requirements. Each resident had the right to be free from . abuse The facility has zero-tolerance for abuse Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse The facility is committed to protecting residents from abuse by anyone, including but not limited to . other residents</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&amp;P titled, Definitions: Operational Manual- Abuse &amp; Neglect, last revised on 1/2025, the P&amp;P indicated, 'Abuse' means the willful infliction of injury . with resulting physical harm, pain, or mental anguish Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, . physical abuse, and mental abuse 'Physical Abuse' means assault, battery, assault with . force likely to produce great bodily injury 'Verbal Abuse' means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents ., or within their hearing distance, regardless of their age, ability to comprehend, or disability.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>43878</p> <p>Based on interview and record review, the facility failed to implement its policy and procedure (P&amp;P) titled, Abuse Prevention and Prohibition Program, by failing to report a physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) to the State Survey Agency (SSA) no later than two hours for one of six sample residents (Resident 5) when on 5/18/2025 at 10:15 a.m. Resident 5 reported to Registered Nurse (RN) 1, that Certified Nursing Assistant (CNA) 2 had handled her roughly. The facility reported the allegation of abuse to the SSA on 5/18/2025 at 2:48 p.m.</p> <p>This deficient practice had the potential to result in unidentified abuse and place Resident 5 at risk for further abuse.</p> <p>Findings:</p> <p>During a review of Resident 5's Admission Record (AR), the AR indicated the facility admitted Resident 5 on 5/16/2025 with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), repeated falls, and respiratory failure (lungs are not working properly to get enough oxygen into your blood and/or remove enough carbon dioxide).</p> <p>During a review of the facility-provided email titled, Accusation employee being rough with resident, dated 5/18/2025 at 2:48 p.m., the email indicated it was reported to the Assistant Administrator (AA) at 2:27 p.m. that Resident 5 reported to her family that her evening CNA (CNA 2) was rough to her.</p> <p>During a review of Resident 5 Incident Note, dated 5/19/2025 at 11:58 a.m., the Incident Note indicated the family member (FM 1) of Resident 5 complained to RN 1 at 10:15 a.m. that the afternoon and night CNA (CNA 2) had handled Resident 5 unpleasantly. Resident 5's FM 1 wanted to ensure CNAs provide gentle care to Resident 5.</p> <p>During a review of Resident 5's Incident Note, dated 5/19/2025 at 12:10 p.m., the Incident Note indicated RN 1 was informed that a verbal write-up will be issued due to the delayed report at 2:20 p.m. for the incident that occurred at 10:15 a.m.</p> <p>During a review of Resident 5's Interdisciplinary Team (IDT- a group of people with different expertise working together to achieve a common goal) Notes, dated 5/19/2025 at 1:43 p.m., the IDT Note indicated on 5/18/2025 at 10:15 a.m. Resident 5 reported that the evening CNA (CNA 2), during Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily), changed the brief unpleasantly. The IDT Note indicated Resident 5 said that it was about 1:30 a.m. to 2 a.m. and Resident 5 was wet and pressed the call light to ask for assistance. The IDT Note indicated Resident 5 said that when CNA 2 arrived, Resident 5 asked to be changed, and CNA 2 started pushing her and Resident 5 thought that she might fall. The IDT Note indicated Resident 5 told CNA 2 she (Resident 5) might fall, and CNA 2 stated so what.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/21/2025 at 1:37 p.m. with Resident 5, Resident 5 stated does not recall the date but it was around 1:30 a.m. Resident 5 needed to be changed and used the call light and CNA 2 came in. Resident 5 stated she asked CNA 2 to be changed in bed. Resident 5 stated CNA 2 began to push Resident 5. Resident 5 stated she was lying on her side and CNA 2 kept pushing her and she Resident 5 felt like she was going to be pushed off the bed because the pushing was rough. Resident 5 stated she asked CNA 2 to stop because she (Resident 5) was going to fall off the bed and CNA 2 responded with so what if you fall. Resident 5 stated the following morning she was telling FM 1 about the incident and the nurse (RN 1) overheard and went to report the incident. Resident 5 stated she told CNA 2 she (CNA 2) was pushing Resident 5 and Resident 5 was going to fall and CNA 2 stated so what. Resident 5 stated this made Resident 5 mad. Resident 5 stated she was scared if she (Resident 5) fell she would break a bone because you never know what could happen, and that was scary. Resident 5 stated if she fell , she would not be able to get up.</p> <p>During an interview on 5/21/2025 at 2:17 p.m. with CNA 2, CNA 2 stated on 5/18/2025 at around 12:30 a.m. or 1 a.m. she was called by Resident 5 through the call light. CNA 2 stated Resident 5 refused to get up and wanted to be changed in bed. CNA 2 stated she turned Resident 5 and Resident 5 complained of pain. CNA 2 stated she asked Resident 5 if she was able to turn and Resident 5 turned on her own. CNA 2 stated Resident 5 stated she was going to fall and CNA 2 stated she responded with no you are not; I will be with you. CNA 2 stated at around 5 p.m. she was informed Resident 5 had complained that CNA 2 had provided care roughly.</p> <p>During an interview on 5/21/2025 at 4:53 p.m. with the Director of Nursing (DON), the DON stated the incident occurred during 11 p.m. to 7:30 a.m. shift on 5/17/2025. The DON stated Resident 5 stated CNA 2 was rough with Resident 5. The DON stated Resident 5 stated CNA 2 kept pushing her and CNA 2 commented if she (Resident 5) fell it was Resident 5's problem, and Resident 5 said she (Resident 5) was not happy with the care. The DON stated there was a delay in reporting the alleged abuse. The DON stated staff were informed in the morning, and they did their investigation prior to contacting the Assistant Director of Nursing (ADON). The DON stated staff knew about the alleged abuse in the morning and did not report until three to four hours later on 5/18/2025, hence, there was a delay. The DON stated that they must report any allegations of abuse within two hours. The DON stated the potential for delay in the reporting can be that the facility staff would not be aware of alleged abuse and CNA 2 could have continued to work with Resident 5 and this could have caused Resident 5 and their family more anxiety.</p> <p>During an interview on 5/22/2025 at 8 a.m. with RN 1, RN 1 stated on 5/18/2025 at 10 a.m. she was informed the family of Resident 5 was complaining about care. RN 1 stated she went to Resident 5's room and FM1 stated Resident 5 complained that CNA 2 was being rough during ADL and pushed Resident 5 to the side which was not gentle. RN 1 stated she went to investigate who worked with Resident 5. RN 1 stated then continued to work and did not report the alleged abuse to the Administrator (Adm). RN 1 stated another nurse reported the alleged abuse around 1 p.m. to the ADON. RN 1 stated allegations of abuse must be reported immediately to the Adm. RN 1 stated there was a potential the health department not to be informed. RN 1 stated the reporting was not done in a timely fashion. RN 1 stated because she did not report in a timely manner there was potential for further abuse. RN 1 stated she informed the 3 to 11 shift RNs not to assign CNA 2 to Resident 5 because there are concerns of abuse with CNA 2 and there is a potential for CNA 2 to abuse other residents.</p> <p>(continued on next page)</p>		

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