STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555579	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ararat Nursing Facility	15099 Mission Hills Road Mission Hills, CA 91345

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a person-centered care plan for four of five sampled residents (Residents 1, 2, 3 and 4) by: 1. Failing to ensure a care plan was develop timely for Resident 1 ' s impulsive behavior of getting up unassisted. 2. Failing to ensure a care plan was develop for Resident 2 ' s diagnosis of osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). 3. Failing to ensure a care plan was develop for Resident 3 ' s behavior of throwing himself (Resident 3) on the floor. 4. Failing to ensure a care plan was develop for Resident 4 ' s diagnosis of osteoporosis. 5. Failing to ensure a care plan was timely develop for Resident 4 ' s behavior of banging the call light on the table. 6. Failing to ensure a care plan was timely develop for Resident 4 ' s refusal of activities of daily living (ADL-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) including shower. These failures had the potential for delayed provision of necessary care and services and placed Residents 1, 2, 3, and 4 at risk for injury. Findings: a. During a record review of Resident 1 ' s admission Record, the admission Record indicated the facility admitted Resident 1 on 7/29/2024, with diagnoses that included unspecified (unconfirmed) heart failure (occurs when the heart can't pump enough blood to meet the body's needs), unspecified dementia, unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and history of falling. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 1 ' s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 7/31/2024, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1 ' s Psychiatry Progress Note dated 9/26/2024, the Psychiatry Progress Note indicated staff reported Resident 1 was observed with episodes of constantly getting up from the wheelchair or bed unassisted. During a record review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool) dated 4/15/2025, the MDS indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 1 was dependent to staff for toileting, needed moderate assistance from staff for sit to stand and needed maximum assistance for transfer and walking. The MDS indicated Resident 1 was frequently incontinent (unable to control) of bowel and bladder functions. The MDS indicated Resident 1 had history of fall since admission. During an interview on 5/30/2025, at 12 p.m., with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated Resident 1 when awake would start moving in bed or wheelchair. CNA 3 stated Resident 1 could stand up but did not have a good balance with walking. CNA 3 stated Resident 1 was a high risk and had history of fall. During a concurrent interview, and record review on 6/3/2025, at 12:08 p.m., with Care Planner 1 (CP 1), Resident 1 ' s Care Plan for at risk for fall developed on 8/9/2024, was reviewed. The Care Plan Indicated Resident 1 was observed on the floor nine times on the following dates: 8/11/2024, 9/20/2024, 10/16/2024, 11/19/2024, 11/25/2024, 12/9/2024, 12/16/2024, 12/31/2024 and 2/17/2025. CP 1 stated Resident 1 was also observed on the floor on 12/27/2024, and 3/20/2025. During an interview on 6/4/2025, at 11:16 p.m., with the Director of Staff Development (DSD), the DSD stated Resident 1 would always try to get up without calling for assistance. During a concurrent interview, and record review on 6/6/2025, at 10:11 a.m., with CP 1, Resident 1 ' s Care Plan on at risk for fall manifested by constantly getting up from wheelchair or bed unassisted dated 3/7/2025 was reviewed. The Care Plan on 3/7/2025 indicated a goal that Resident 1 will have decreased episode of constantly getting up from wheelchair or bed unassisted. During a concurrent interview, and record review on 6/6/2025, at 12:32 p.m. with the Director of Nursing (DON), Resident 1 ' s Care Plan on at risk for fall manifested by constantly getting up from wheelchair or bed unassisted dated 3/7/2025, was reviewed. The DON stated care plan should have been created when nurses first observed the behavior. The DON stated the facility failed to create a care plan timely. b. During a review of Resident 2 ' s admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included atherosclerotic heart disease (the arteries that supply blood to your heart become hardened and narrowed due to the buildup of plaque), Alzheimer ' s Disease (a disease characterized by a progressive decline in mental abilities) and age-related osteoporosis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2 ' s H&P dated 3/1/2025, the H&P indicated Resident 2 had no capacity to understand and make decisions. During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 ' s cognitive skills for daily decisions was moderately impaired. The MDS indicated Resident 2 needed maximum assistance from staff for oral hygiene, showering, dressing, personal hygiene and transfer. The MDS indicated Resident 2 needed supervision with walking. During a concurrent interview, and record review on 6/3/2025, at 9:20 a.m., with CP 2, Resident 2 ' s admission Record, Physician Progress Notes dated 4/15/2025, and Care Plans was reviewed. The admission Record indicated a diagnosis of age-related osteoporosis on 9/14/2023. CP 2 stated care plan for osteoporosis was resolved on 3/23/2022. CP 2 stated care plan should still be active. CP 2 stated the Physician Progress Notes dated 4/15/2025, indicated the physician documented diagnosis of osteoporosis. CP 2 stated she (CP 2) missed developing a new care plan for osteoporosis. CP 2 stated the importance of developing a care plan was to guide and notify nurses that Resident 2 was at risk for fracture (break in the bone). During an interview on 6/3/2025, at 11:14 a.m., with Risk Management Nurse (RMN), the RMN stated Resident 2 who had a history of osteoporosis should have a care plan. The RMN stated care plan help address resident needs. During an interview on 6/4/2025, at 12:52 p.m., with the DON, the DON stated CP 2 should have developed a care plan for osteoporosis. The DON stated the facility failed to develop a care plan for the diagnosis of osteoporosis. c. During a review of Resident 3 ' s admission Record, the admission Record indicated the facility admitted Resident 3 on 1/17/2025, with diagnoses that included Parkinson ' s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), unspecified Alzheimer ' s, muscle weakness and age-related osteoporosis. During a review of Resident 3 ' s H&P dated 4/18/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3 ' s MDS dated [DATE], the MDS indicated Resident 3 ' s cognitive skills for daily decision making severely impaired. The MDS indicated Resident 3 was dependent to staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 3 had a fall incident in the last two to six months before admission. During a review of Resident 3 ' s Post Fall Summary/Intervention dated 5/26/2025, the Post Fall Summary/Intervention indicated Resident 3 was observed on the floor on 5/25/2025 at 2 p.m. During an interview on 5/30/2025, at 11:25 a.m., with CNA 10 and translated by Central Supply Coordinator (CSC), CNA 10 stated Resident 3 moves a lot in the bed. CNA 10 stated Resident 3 attempts to get out of the bed unassisted. CNA 10 stated nurses are aware that he (Resident 3) does want to get out of the bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, and record review on 6/3/2025, at 9:54 a.m., with CP 1, Resident 3 ' s Progress Notes dated 5/6/2025 to 5/24/2025 was reviewed. The Progress Notes indicated from 5/6/2025 to 5/10/2025, 5/13/2025, and 5/15/2025 to 5/24/2025, Licensed Vocational Nurse (LVN) ' s 5, 6, and 7 documented that Resident 3 was observed with behavior of throwing himself (Resident 3) on the floor and cannot stay in the room unattended. CP 1 stated there were no reported behavior that Resident 3 throws himself on the floor so care plan was not developed. During an interview on 6/3/2025, at 10:20 a.m., with Performance Improvement Quality Improvement Nurse 1 (PIQIN 1), PIQIN 1 stated nurses should report Resident 3 ' s behavior of throwing himself (Resident 3) on the floor so the facility can develop a care plan with interventions to prevent fall for resident safety. During a concurrent interview, and record review on 6/3/2025, at 11:14 a.m., with the RMN, Resident 3 ' s Progress Notes dated 5/6/2025 to 5/25/2025, was reviewed. The RMN stated LVNs 5, 6, and 7 documented Resident 3 ' s behavior of throwing himself (Resident 3) on the floor almost daily, 16 times from 5/6/2025 to 5/24/2025 and on 5/25/2025, Resident 3 had a fall. The RMN stated nurses should report any behavior or change in condition so care plan could be developed to address Resident 3 ' s behavior. During an interview on 6/4/2025, at 12:52 p.m., with the DON, the DON stated care plan should have been developed when nurses first observed and documented the behavior of Resident 3 ' s throwing himself on the floor on 5/6/2025. d. During a review of Resident 4 ' s admission Record, the admission Record indicated the facility admitted Resident 4 on 4/19/2022, with diagnoses that included unspecified atrial fibrillation (irregular heartbeat), generalized idiopathic epilepsy (a type of epilepsy where seizures originate in both sides of the brain simultaneously) and age-related osteoporosis. During a review of Resident 4 ' s MDS dated [DATE], the MDS indicated Resident 4 ' s cognitive skills for daily decision making was moderately impaired. During a review of Resident 4 ' s H&P dated 4/24/2025, the H&P indicated Resident 4 had fluctuating capacity to understand and make decisions. During a concurrent interview, and record review on 6/5/2025, at 9:27 a.m., with CP 1, Resident 4 ' s care plans were reviewed. CP 1 stated there was no care plan developed for Resident 4 ' s diagnosis of osteoporosis. During an interview on 6/5/2025, at 10:47 a.m., with the DON, the DON stated care plan should have been developed for Resident 4 ' s diagnosis of osteoporosis. e. During a review of Resident 4 ' s Registered Nurse (RN)/LVN Progress Notes dated 4/10/2025, the RN/LVN Progress Notes indicated on 4/10/2025, at 3:30 p.m., Resident 4 screamed and used the call light to hit the desk. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4 ' s RN/LVN Progress Notes dated 4/17/2025, at 11:45 a.m., Resident 4 complained of right-hand middle finger pain. The RN/LVN Progress Notes indicated Resident 4 ' s right middle finger appeared bruised and swollen. The RN/LVN Progress Notes also indicated even with bruised finger Resident 4 still bangs her (Resident 4) hand on the table to call for the nurse. During an interview on 6/4/2025, at 10:59 a.m., with CNA 13, CNA 13 stated CNA 10 was the assigned regular CNA for Resident 4. CNA 13 stated Resident 4 would bang the call light every day but on 4/17/2025, it was out of control. During an interview on 6/4/2025, at 3:46 p.m., with CNA 12, CNA 12 stated Resident 4 had a habit of banging her call light on the table. CNA 12 stated nurses were aware of her behavior. During an interview on 6/5/2025, at 8:12 a.m., with LVN 8, LVN 8 stated since she (LVN 8) started four to five months ago, Resident 4 used her right hand to bang her call light on the table and that was her (Resident 4) way of calling for assistance. LVN 8 stated she (LVN 8) had reported to the RN but not familiar with RN names yet at that time. During an interview on 6/5/2025, at 9:27 a.m., with CP 1, CP1 stated the nurses reported Resident 4 ' s behavior of using the call light to hit the table on 4/17/2025. CP 1 stated they were not informed of Resident 4 ' s behavior before 4/17/2025. CP 1 stated nurses where informed to monitor and observed a one-time behavior but if the behavior continued that nurses need to report to CP ' s so a care plan could be developed. During an interview on 6/5/2025, at 10:47 a.m., with the DON, the DON stated if nurses had observed Resident 4 ' s behavior of hitting the table with the call light, nurses should have reported and documented so care plan could have been developed. The DON stated care plan should have been developed for any change in condition. f. During a record review of Resident 4 ' s Interdisciplinary (IDT-a coordinated group of experts from several different fields who work together) Care Conference Review dated 2/7/2025, the IDT indicated Resident 4 refused CNA ' s assistance with ADL. During a review of Resident 4 ' s Documentation Survey Report, dated 2/2025, to 5/5/2025, about ADL-hygiene and showering, the Documentation Survey Report indicated Resident 4 had refused shower on 2/3/2025, 2/14/2025, 2/28/2025, 3/3/2025, 3/28/2025, 4/23/2025 and 4/25/2025. During an interview on 6/4/2025, at 10:59 a.m., with CNA 13, CNA 13 stated Resident 4 refused shower sometimes. During an interview on 6/5/2025, at 8:44 a.m., with the DSD, the DSD stated Resident 4 had a tendency of refusing shower. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, and record review on 6/5/2025, at 9:27 a.m., with CP 1, Resident 4 ' s Care Plans, and IDT notes dated 2/7/2025, were reviewed. The IDT dated 2/7/2025, indicated Resident 4 ' s refusal with ADL. CP 1 stated a care plan for shower refusal was developed on 5/1/2025. CP 1 stated she (CP 1) was not informed of Resident 4 ' s refusal until 5/1/2025. CP 1 stated there were no care plan developed for Resident 4 ' s refusal with ADL. CP 1 stated care plans are reviewed quarterly (every three months). CP 1 stated she (CP 1) should have developed a care plan on refusal on 2/17/2025 when the IDT happened. CP 1 stated she (CP 1) should have caught that there was no care plan for ADL refusal on 4/2025 during the quarterly review of care plans. During an interview on 6/5/2025, at 10:47 a.m., with the DON, the DON stated it was the CP ' s fault that they did not develop the care plan for Resident 4 ' s refusal with ADL and shower. The DON stated care plan should have been created on 2/2025 when Resident 4 had refused ADL and shower. During an interview on 6/6/2025, at 12:03 p.m., with the RMN, the RMN stated care plan should have been developed timely when Resident 4 had a change of condition, when resident refused treatment or when resident had any behavior. During a review of facility ' s policy and procedure (P&P) titled, Care Planning dated 3/7/2025, and last reviewed on 4/28/2025, the P&P indicated, To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs II. The Care Plan serves as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's Attending Physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs. III. A Licensed Nurse will initiate the Care Plan, and the plan will be finalized in accordance with OBRA/MDS guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgment on an ass needed bases. VIII. A culturally competent and trauma-informed Comprehensive Care Plan will be developed for each resident. The Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs. A. In the event that the Comprehensive Care Plan identified a change in the resident's goals or functioning that was not identified in the Baseline Care Plan, these changes will be incorporated into an updated summary and provided to the resident and/or resident's representative. B. Changes may be made to the Comprehensive Care Plan on an ongoing basis for the duration of the resident's stay. These subsequent changes will not need to be reflected through updates to the Baseline Care Plan. IX. Each resident's Comprehensive Care Plan will describe the following· A. Services that are to be furnished to attain or maintain the resident highest practicable. physical, mental and psychosocial well-being; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Any services that would be required, but are not provided due to the resident's exercise of rights, which includes the right to refuse treatment;

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review, the facility failed to ensure that one of the four sampled residents (Resident 4), who was unable to carry out activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) received the necessary services to maintain good grooming and personal hygiene. This failure had the potential to negatively affect Resident 4' s self-esteem and wellbeing and placed Resident 4 at risk of infection. Findings: During a review of Resident 4 ' s admission Record, the admission Record indicated the facility admitted Resident 4 on 4/19/2022, with diagnoses that included unspecified atrial fibrillation (irregular heartbeat), generalized idiopathic epilepsy (a type of epilepsy where seizures originate in both sides of the brain simultaneously) and age-related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 4 ' s Minimum Data Set (MDS-a resident assessment tool) dated 1/28/2025, the MDS indicated Resident 4 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was moderately impaired. The MDS indicated Resident 4 needed maximum assistance from staff with shower and bathing. During a review of Resident 4 ' s History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 4/24/2025, the H&P indicated Resident 4 had fluctuating capacity to understand and make decisions. During a record review of Resident 4 ' s Interdisciplinary (IDT-a coordinated group of experts from several different fields who work together) Care Conference Review dated 2/7/2025, the IDT indicated Resident 4 refused CNA ' s assistance with ADL. During a review of Resident 4 ' s Documentation Survey Report, dated 2/2025, to 5/5/2025, about ADL-hygiene and showering, the Documentation Survey Report indicated Resident 4 was not provided a shower from 2/1/2025, to 2/16/2025, and from 4/17/2025, to 4/28/2025. During an interview on 6/4/2025, at 10:59 a.m., with Certified Nursing Assistant 13 (CNA 13), CNA 13 stated Resident 4 refuses shower sometimes and LVNs are informed. During an interview on 6/5/2025, at 8:32 a.m., with CNA 14, CNA 14 stated Resident 4 refuses shower and only wanted shower with the assistance of CNA 15. During an interview on 6/5/2025, at 8:44 a.m., with the DSD, the DSD stated Resident 4 had a tendency of refusing shower. The DSD stated Resident 4 was on shower schedule twice a week. The DSD stated CNA 15 was the regular assigned CNA but if CNA 15 was not on the schedule, Resident 4 had the tendency to refuse. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview, and record review on 6/5/2025, at 9:58 a.m., with the Information System Staff (ISS), Resident 4 ' s Documentation Survey Report about ADL-hygiene and showering dated 2/2025 to 5/2025 was reviewed. The ISS stated Resident 4 did not receive a shower from 4/17/2025 to 4/28/2025. During an interview on 6/5/2025, at 10:08 a.m., with the DSD, the DSD stated Resident 4 did not received a shower for two weeks on 4/2025. During a concurrent interview, and record review on 6/5/2025, at 9:27 a.m., with Care Planner (CP) 1, Resident 4 ' s Care Plans, and Interdisciplinary Team (IDT) notes dated 2/7/2025, were reviewed. The IDT dated 2/7/2025, indicated Resident 4 ' s refusal with ADL. CP 1 stated a care plan for shower refusal was developed on 5/1/2025. CP 1 stated she (CP 1) was not informed of Resident 4 ' s refusal until 5/1/2025. CP 1 stated there were no care plan developed for Resident 4 ' s refusal with ADL. CP 1 stated care plans are reviewed quarterly (every three months). CP 1 stated she (CP 1) should have developed a care plan on refusal on 2/17/2025 when the IDT happened. CP 1 stated she (CP 1) should have caught that there was no care plan for ADL refusal on 4/2025 during the quarterly review of care plans. During an interview on 6/5/2025, at 10:47 a.m., with the Director of nursing (DON), the DON stated Resident 4 had no shower for two weeks on 4/2025. The DON stated shower should be provided at least twice a week and if resident refused, physician should be notified. The DON stated the importance of bathing and showering was it removes dead skin cells, refreshes residents and gives opportunities for CNAs to check residents skin but mostly for hygiene purposes. During a review of facility ' s policy and procedure (P&P) titled, Showering a Resident dated 8/1/2014 and last reviewed on 4/28/2025, the P&P indicated, A shower bath is given to the residents to provide cleanliness, comfort and to prevent body odors. Residents are offered a shower at a minimum of once weekly and given per resident request.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents received care consistent with professional standards of practice for two of four sampled residents (Resident 1 and Resident 2) by: 1. Failing to ensure vital signs (measurements that indicate the status of a person's body's vital functions and are used to assess overall health) were taken when Resident 1 fell on 5/21/2025. 2. Failing to ensure Resident 1 ' s neurochecks (neurological assessments that nurses perform to monitor a patient's neurological status, especially when a patient has a condition that could affect their brain or nervous system function) were assessed after the falls on 10/16/2024, 12/31/2024 and 5/21/2025 as indicated in the facility ' s Neurological Assessment policy. 3. Failing to ensure Resident 2 ' s neurochecks were assessed after the falls on 1/3/2025 and 5/21/2025 as indicated in the facility ' s Neurological Assessment policy. These failures had the potential for a delay in care and services to Resident 1 and Resident 2. Findings: a. During a record review of Resident 1 ' s admission Record, the admission Record indicated the facility admitted Resident 1 on 7/29/2024, with diagnoses that included unspecified (unconfirmed) heart failure (occurs when the heart can't pump enough blood to meet the body's needs), unspecified dementia (a progressive state of decline in mental abilities), unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and history of falling. During a record review of Resident 1 ' s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 7/31/2024, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a record review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool) dated 4/15/2025, the MDS indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 1 was dependent to staff for toileting, needed moderate assistance from staff for sit to stand and needed maximum assistance for transfer and walking. The MDS indicated Resident 1 was frequently incontinent (unable to control) of bowel and bladder functions. The MDS indicated Resident 1 had history of fall since admission. During a review of Resident 1 ' s Progress Notes, dated 5/21/2025, the Progress Notes indicated on 5/21/2025, at 9:50 p.m., Resident 1 was seated in a wheelchair in front of the nurse ' s station when RN 1, LVN 1 and LVN 2 observed Resident 1 got out of the wheelchair and walked one step and fall. The Progress Notes indicated Resident 1 had 3 centimeters (cm- a unit of length in the metric system) in length by 0.5 cm in width right eyebrow laceration with bleeding. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ararat Nursing Facility	15099 Mission Hills Road Mission Hills, CA 91345

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, and record review on 6/3/2025, at 10:20 a.m., with Performance Improvement Quality Improvement Nurse (PIQIN 1), Resident 1 ' s Progress Notes dated 5/21/2025, and Weights and Vital Summary dated 5/21/2025, were reviewed. PIQIN 1 stated there were no documented vital signs when Resident 1 fell on 5/21/2025. PIQIN 1 stated vital signs is part of resident assessment and its necessary to check vital signs after a fall to find out the cause of a fall if it was from a low blood pressure or from low blood sugar. PIQIN 1 stated vital signs is necessary when calling the physician of a change in condition. During a concurrent record review, Resident 1 ' s neurocheck after the 5/21/2025, was reviewed with PIQI 1. The PIQI 1 stated Resident 1 ' s neurocheck after the 5/21/2025 fall was not in Resident 1 ' s medical record. During an interview on 6/3/2025, at 11:14 a.m., with the Risk Management Nurse (RMN), the RMN stated vital signs is important to check after Resident 1 ' s fall to see if there were any contributing factors to the fall incident. The RMN stated vital signs is part of the assessment that should be relayed to the physician. The RMN stated nurses should check vital signs and document. During a concurrent interview and record review on 6/4/2025, at 11:48 a.m., with the RMN, Resident 1 ' s neurocheck assessments dated 10/16/2024, 12/31/2024, and 5/21/2025 were reviewed. The RMN stated there were no documented neurochecks after Resident 1 ' s falls on 10/16/2024, 12/31/2024, and 5/21/2025. The RMN stated the importance of neurologic assessment was to find out if the neurological status of Resident 1 was affected after the fall incidents. During a concurrent on 6/4/2025, at 12:52 p.m., with the Director of Nursing (DON), the DON stated Resident 1 ' s vital signs was not documented on 5/21/2025 fall. The DON stated the facility ' s Interdisciplinary Team (IDT- a coordinated group of experts from several different fields who work together) team failed to catch that vital sign was missing on the 5/21/2025 fall. The DON stated vital signs is part of assessment after each change of condition. The DON stated a neurocheck is done when residents fall and hit their head and during an unwitnessed fall. The DON stated the importance of neurochecks was to help identify any significant change as a result of a fall. The DON stated if staff did not do a nuerocheck after the fall the staff would not be able to know if there was a change in residents ' condition that might cause a delay in care. During a concurrent interview, and record review on 6/5/2025, at 10:47 a.m., with the DON, the facility ' s policy and procedure (P&P) titled, Fall Risk Assessment, last reviewed on 4/28/2025, was reviewed. The P&P indicated, The Licensed Nurse will use the Fall Risk Assessment Form to help identify individuals with a history of falls and risk factors for subsequent falling. The assessment will be completed upon admission, quarterly (every three months), and with a significant change in condition. The DON stated when residents fall, nurses should do a fall risk assessment. The DON stated the facility failed to assess Resident 1 ' s fall risk after the incident on fall. During a concurrent record review of the facility ' s P&P titled, Change of Condition Notification, dated and last reviewed on 4/28/2025, the P&P indicated, I. The Licensed Nurse will notify the resident's Attending Physician when there is an: A. Incident/accident involving the resident; B. An accident involving the resident which results injury and has the potential for requiring physician intervention; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. The Licensed Nurse will assess the resident's change of condition and document the observations and symptoms. III. Notifying the Attending Physician . B. Notification to the Attending Physician will include a summary of the condition change and an assessment of the resident's vital signs and system review focusing on the condition and/or signs and symptoms for which the notification is required. The DON stated with any change of condition like fall, vital signs is included. The DON stated without the vital signs the nurses would have an incomplete report to the physician. The DON stated the facility failed to check and document Resident 1 ' s vital signs after the fall on 5/21/2025. b. During a review of Resident 2 ' s admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included atherosclerotic heart disease (the arteries that supply blood to your heart become hardened and narrowed due to the buildup of plaque), Alzheimer ' s Disease and age-related osteoporosis (a condition where bone density and strength decrease as people age, primarily due to a decrease in bone-building cells and an increase in bone-resorbing cells). During a review of Resident 2 ' s Licensed Nurses Progress Notes dated 1/3/2025, the Licensed Nurses Progress Notes indicated on 1/3/2025 at 3:20 a.m., heard a noise from Resident 2 ' s room and found Resident 2 lying on her (Resident 2) right side, on the floor between the toilet bowl and the bathroom wall. The Licensed NursesProgress Notes indicated Resident 2 had a skin tear on the right side of the face. The Licensed Nurses Progress Notes indicated physician was notified with order to transfer Resident 2 to a GACH via 911. During a review of Resident 2 ' s H&P dated 3/1/2025, the H&P indicated Resident 2 had no capacity to understand and make decisions. During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 ' s cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 2 needed maximum assistance from staff for oral hygiene, showering, dressing, personal hygiene and transfer. The MDS indicated Resident 2 needed supervision with walking. During a review of Resident 2 ' s Progress Notes dated 5/21/2025, timed at 10:56 p.m., the Progress Notes indicated on 5/21/2025, at 9:30 p.m., CNA 5 reported that Resident 2 was found on the floor. The Progress Notes indicated Resident 2 complained of right hip pain and unable to move her (Resident 2) right leg. The Progress Notes indicated the physician was notified with order to transfer Resident 2 to GACH via 911. During a concurrent interview and record review on 5/30/2025, at 11:35 a.m , with LVN 4, Resident 2 ' s Licensed Nurses Progress Notes and Nuerocheck assessment dated [DATE] and 5/21/2025 were reviewed. LVN 4 stated Resident 2 had fall incident on 1/3/2025, and 5/21/2025. LVN 4 stated there were no neurochecks on 1/3/2025 and 5/21/2025 in Resident 2 ' s medical record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/2025, at 11:48 a.m., with the RMN, the RMN stated the importance of neurologic assessment was to find out if Resident 2 ' s neurological status was affected after the fall incident. The RMN stated neurocheck is part of nurse ' s assessment after a fall. During an interview on 6/4/2025 at 12:52 p.m. with the DON, the DON stated neurocheck is done when a resident fall and hit their head and during an unwitnessed fall. The DON stated the importance of neurocheck was to help identify any significant change as a result of a fall. The DON stated if staff did not do a nuerocheck after the fall the staff would not be able to know if there was a change in residents ' condition that might cause a delay in care. The DON stated neurocheck is basic nursing care that nurses forget. During a review of the facility ' s P&P titled, Neurological Assessment, dated 8/1/2014, and last reviewed on 4/28/2025, the P&P indicated, To provide guidelines for the performance of a neurological assessment on residents. I. Nursing Staff will perform a neurological assessment in the following circumstances . B. Following an unwitnessed fall; C. Following a fall or other accident/injury involving head trauma; II. Neurological checks will be performed as follows or otherwise ordered by the Attending Physician: A. Every 15 minutes for 1 hour, then; B. Every 30 minutes for 1 hour, then; C. Every hour for 2 hours, then; D. Every 4 hours for a combined total of 72 hours IX. Documentation A. The following information will be documented in the resident's medical record: i. The date and time the procedure was performed; ii. The name and title of the individual(s) who performed the procedure; iii. All assessment data obtained during the procedure, including: a. Eye opening b. Verbal response c. Motor response (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Pupillary (black circle in the center of the eye) response e. Limb (arms or legs) response. During a review of facility ' s P&P titled, Response to Fall dated 3/31/2025, and last reviewed on 4/28/2025, the P&P indicated, Post-Fall Assessment and Monitoring: The Licensed Nurse will also complete the Neurological Flow Sheet for any un-witnessed fall or witnessed fall with known head injury for 72 hours following the fall. Documentation: A. License Nurse . v. Complete Neurological Flow Sheet for 72 hours following an un-witnessed fall or fall with known head injury.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one of four sampled residents (Resident 2) who had an indwelling urinary catheter (a flexible plastic tube inserted into the bladder that remains there to provide continuous urinary drainage) received proper care and services by failing to ensure Resident 2 ' s urine color and consistency was assessed per physician order. This failure had the potential to result in urinary tract infection (UTI- an infection in the bladder/urinary tract) and had potential to lead to urosepsis (a potentially life-threatening complication of urinary tract infection). Findings: During a review of Resident 2 ' s admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included atherosclerotic heart disease (the arteries that supply blood to your heart become hardened and narrowed due to the buildup of plaque), Alzheimer ' s Disease (a disease characterized by a progressive decline in mental abilities) and age-related osteoporosis (a condition where bone density and strength decrease as people age, primarily due to a decrease in bone-building cells and an increase in bone-resorbing cells). During a review of Resident 2 ' s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 3/1/2025, the H&P indicated Resident 2 had no capacity to understand and make decisions. During a review of Resident 2 ' s Minimum Data Set (MDS- a resident assessment tool), dated 4/9/2025, the MDS indicated Resident 2 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 2 needed maximum assistance from staff for oral hygiene, showering, dressing, personal hygiene and transfer. During a concurrent observation, and interview on 5/30/2025, at 8:30 a.m., in Resident 2 ' s bedside, Resident 2 had a urinary catheter draining yellow urine with a privacy bag. During a concurrent interview, and record review on 5/30/2025, at 12:10 p.m., with Treatment Nurse 1 (TN 1), Resident 2 ' s Medication Administration Record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 5/2025 and Progress Notes, dated 5/28/2025 to 5/30/2025 were reviewed. TN 1 stated there were no documented assessment and monitoring of Resident 2 ' s urine color and consistency until today 5/30/2025. TN 1 stated Resident 2 ' s urine if not monitored could result to infection and kidney stones (hard object that is made from chemicals in the urine). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview, and record review on 5/30/2025, at 12:43 p.m., with Registered Nurse 4 (RN 4), Resident 2 ' s Physician Order dated 5/28/2025 was reviewed. The Physician Order indicated to assess Resident 2 ' s urine for color and consistency (sedimentation-alert health care providers to the presence of kidney disease) every shift. RN 4 stated nurses, assess and document urine color and consistency in the Progress Notes or in MAR. RN 4 stated the facility failed to document assessment of urine for color and consistency. RN 4 stated not assessing urine might cause urinary infection. During a concurrent interview, and record review on 6/3/2025, at 11:14 a.m., with the Risk Management Nurse (RMN), Resident 2 ' s MAR, dated 5/2025 was reviewed. The RMN stated Resident 2 was readmitted to the facility on [DATE], at 6:20 p.m. The RMN stated urine assessment should have been started at least the following day on 5/29/2025. The RMN stated there were no monitoring for urine assessment on 5/29/2025 and was just started today 5/30/2025. The RMN stated the facility failed to follow the physician order. During an interview on 6/4/2025, at 12:52 p.m., with the Director of Nursing (DON), the DON stated the facility failed to follow physician order for assessing urine color and consistency every shift on 5/29/2025. The DON sated the nurses should have validated the order and follow the physician order to assess and document Resident 2 ' s urine. The DON stated the importance of urine assessment was to notify the physician immediately of any change in condition to prevent UTI. During a concurrent interview, and record review on 6/5/2025, at 10:47 a.m., with the DON, facility ' s policy and procedure (P&P) titled, Care of Catheter, dated 9/1/2014, and last reviewed on 4/28/2025, the P&P indicated, To prevent catheter-associated urinary tract infections while ensuring that residents are not given indwelling catheters unless medically necessary . V. A resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible . L. Report the following signs and symptoms to the Attending Physician: i. Any sign or symptom of urinary tract infection (UTI): fever, change in urine, such as a foul odor or bloody/cloudy appearance. ii. No urine output or decreased urine output iii. Leakage of urine iv. Hematuria (bloody urine) . The DON stated the nurses should monitor Resident 2 ' s urine for color, clarity and consistency.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer pain medication for one of four sampled residents (Resident 2) as per physician ' s order to administer Tylenol (medication used to treat pain) as needed for pain when Resident 2 had an incident of fall on 5/21/2025 and had a pain level of six out of ten using the pain scale (a tool used to help people describe and quantify their pain). This failure had the potential to negatively affect the Resident 2 ' s physical comfort and had the potential to increase the pain level and result in an unmanageable pain. Findings: During a review of Resident 2 ' s admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included atherosclerotic heart disease (the arteries that supply blood to your heart become hardened and narrowed due to the buildup of plaque), Alzheimer ' s Disease (a disease characterized by a progressive decline in mental abilities) and age-related osteoporosis (a condition where bone density and strength decrease as people age, primarily due to a decrease in bone-building cells and an increase in bone-resorbing cells). During a review of Resident 2 ' s Physician Order dated 3/13/2021, the Physician Order indicated Tylenol oral tablet 326 milligram (mg- metric unit of measurement, used for medication dosage and/or amount), give two tablets by mouth every four hours as needed for mild pain or general discomfort. During a review of Resident 2 ' s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 3/1/2025, the H&P indicated Resident 2 had no capacity to understand and make decisions. During a review of Resident 2 ' s Minimum Data Set (MDS-a resident assessment tool) dated 4/9/2025, the MDS indicated Resident 2 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was moderately impaired. The MDS indicated Resident 2 needed maximum assistance from staff for oral hygiene, showering, dressing, personal hygiene and transfer. During a review of Resident 2 ' s Progress Notes dated 5/21/2025, timed at 10:56 p.m., the Progress Notes indicated on 5/21/2025, at 9:30 p.m., Certified Nursing Assistant 5 (CNA 5) reported that Resident 2 was found on the floor. The Progress Notes indicated Resident 2 complained of right hip pain and unable to move her (Resident 2) right leg. The Progress Notes indicated the physician was notified at 9:56 p.m., and family informed at 10:05 p.m. During a review of Resident 2 ' s Progress Notes dated 5/22/2025, timed at 10:31 a.m., the Progress Notes indicated on 5/21/2025, at 10:15p.m., Resident 2 was transferred to the General Acute Care Hospital (GACH). During a review of Resident 2 ' s Medication Administration Record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 5/2025, the MAR indicated no Tylenol was administered to Resident 2 on 5/21/2025. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s Weights and Vitals Summary dated 5/21/2025, the Weights and Vitals Summary indicated on 5/21/2025, at 9:45 p.m., Resident 2 had a pain level of six out of ten. During an interview on 5/30/2025, at 9:13 a.m. with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated on 5/21/2025, at 9:15 p.m., Resident 2 was observed in bed and at 9:30 p.m., Resident 2 was found on the floor. LVN 3 stated she (LVN 3) was with another resident when CNA 5 reported that Resident 2 was on the floor. LVN 3 stated Resident 2 complained of right hip pain. LVN 3 stated she (LVN 3) checked Resident 2 ' s vital signs (measurements that indicate the status of a person's body's vital functions and are used to assess overall health) and Registered Nurse 2 (RN 2) called 911 (emergency medical response). LVN 3 stated Resident 2 was not transferred back to bed due to pain and waited for the paramedics to transfer Resident 2 to GACH. During an interview on 5/30/2025, at 9:21 a.m., with RN 2, RN 2 stated he (RN 2) was in a different nursing station when LVN 3 reported that Resident 2 was found on the floor. RN 2 stated when he (RN 2) came inside Resident 2 ' s room, Resident 2 was on the floor with no floor mat. RN 2 stated upon assessment, Resident 2 complained of right hip pain, Resident 2 could not move the right leg and Resident 2 was guarding her (Resident 2) right hip. RN 2 stated he (RN 2) called the physician, 911 and the family. During an interview on 6/3/2025, at 8:35 a.m., with RN 2, RN 2 stated Resident 2 complained of pain after the 5/21/2025 fall and LVN 3 should have medicated Resident 2 for pain while waiting for the paramedics to pick up Resident 2. RN 2 stated pain medication help relieves pain and if not given when Resident 2 complained of pain, the pain could get worst and cause severe pain and discomfort. During a concurrent interview, and record review on at 11:14 a.m., with the Risk Management Nurse (RMN), Resident 2 ' s Physician Order dated 3/13/2021, MAR dated 5/2025, and Weights and Vital Summary dated 5/21/2025 were reviewed. The RMN stated Resident 2 had a pain level of six out of ten on 5/21/2025 at 9:45 p.m. The RMN stated no pain medication was given to Resident 2 according to the MAR. The RMN stated Resident 2 had an order for Tylenol and LVN 3 should have offered the pain medicine and document if administered or if Resident 2 refused. The RMN stated not administering pain medicine can cause Resident 2 to experience unmanageable pain and discomfort. During an interview on 6/4/2025, at 12:52 p.m., with the Director of Nursing (DON), the DON stated Resident 2 was not medicated for pain after the 5/21/2025 fall. The DON stated Tylenol could have help ease Resident 2 ' s pain and discomfort. The DON stated the facility failed to follow physician order for pain medication administration. During a concurrent interview, and record review on 6/5/2025, at 10:47 a.m., with the DON, facility ' s policy and procedure (P&P) titled Pain Management, dated 8/1/2024, and last reviewed on 4/28/2025, the P&P indicated, The License Nurse will administer pain medication as ordered and document all the medication administered on the Medication Administration Record (MAR) Nursing Staff will implement timely interventions to reduce the increase in severity of pain. The DON stated nurses should have medicated Resident 2 for pain when Resident 2 complained of pain according to the physician order and if there was no order for pain medicine, nurses should be calling the physician to get an order and help relieve Resident 2 ' s pain.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for two of four sampled residents (Residents 1 and 4) by: 1. Failing to ensure Resident 1 ' s physician order to administer cephalexin (antibiotic medication that treats infection [harmful germs have entered your body and are causing problems]) for five days was followed. 2. Failing to ensure Resident 1 ' s physician order was followed for Humulin R (medication used to manage blood sugar level) administration. 3. Failing to ensure 12 medications of Resident 4 ' s were not provided to Family Member (FM 2) without a physician order. These failures had resulted to incomplete dose of cephalexin that may potentially prolong infection, may potentially cause hypoglycemia (low blood sugar) and medication error to Resident 2. Also, this failure had the potential to had a negative outcome to Resident 4 if the medications were not given to Resident 4 as ordered by the physician. Findings: a. During a record review of Resident 1 ' s admission Record, the admission Record indicated the facility admitted Resident 1 on 7/29/2024, with diagnoses that included unspecified (unconfirmed) heart failure (occurs when the heart can't pump enough blood to meet the body's needs), unspecified dementia, unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a record review of Resident 1 ' s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 7/31/2024, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a record review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool) dated 4/15/2025, the MDS indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 1 was dependent to staff for toileting, needed moderate assistance from staff for sit to stand and needed maximum assistance for transfer and walking. During a review of Resident 1 ' s Order Audit Report dated 5/22/2025, the Order Audit Report indicated cephalexin oral capsule 500 milligram (mg- metric unit of measurement, used for medication dosage and/or amount), give one capsule by mouth every six hours for infection of laceration (a tear or cut in the skin or deeper tissues, often with jagged edges) on the right eyebrow for five days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555579	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ararat Nursing Facility	15099 Mission Hills Road Mission Hills, CA 91345

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Medication Administration Record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 5/2025, the MAR indicated on 5/26/2025, at 12 a.m., and 6 a.m., MAR was left blank and on 5/26/2025 at 12 p.m., cephalexin was not administered. During a review of Resident 1 ' s Progress Notes, dated 5/26/2025, timed at 12:24 p.m., the Progress Notes indicated cephalexin was not in the medication cart. During a concurrent interview, and record review on 6/3/2025, at 10:20 a.m., with the Performance Improvement Quality Improvement Nurse 1 (PIQIN 1), Resident 1 ' s MAR dated 5/2025 was reviewed. PIQIN 1 stated according to the MAR, Resident 1 missed three doses of cephalexin. PIQIN 1 stated the physician needed to be notified when medication is not available, and pharmacy need to be informed so antibiotic could be obtained from the emergency kit (ekit- small supply of medication that can be used when pharmacy services are unavailable. Emergency kits are designed to help nursing facilities provide medication to their residents during emergencies) if available. During a concurrent interview, and record review on 6/3/2025, at 11:14 a.m., with the Risk Management Nurse (RMN), Resident 1 ' s Order Summary Report dated 5/22/2025, was reviewed. The RMN stated the physician ordered cephalexin every six hours for five days and Resident 1 missed three doses of antibiotic cephalexin. The RMN stated nurses should have called the physician and the pharmacy. The RMN stated missing doses of antibiotic could result to unresolved infection. During an interview on 6/4/2025, at 12:52 p.m., with the Director of Nursing (DON), the DON stated if MAR is blank, it means medication was not administered. The DON stated if medication was not available, nurses should have called the pharmacy and Registered Nurse Supervisor should have track why medication was not delivered. The DON stated the nurses did not follow through causing Resident 1 to received incomplete dose of antibiotic. The DON stated incomplete dose of antibiotic will not help fight Resident 1 ' s infection. The DON stated the facility failed to follow the physician order. During a review of facility ' s policy and procedure (P&P), titled, Medication-Administration dated 7/1/2016, and last reviewed on 4/28/2025, the P&P indicated, Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner. b. During a review of Resident 1 ' s Physician Order, dated 12/11/2024, the Physician Order indicated Humulin R injection 100 units per milliliter (ml- a unit of volume) give eight units subcutaneously (an injection administered into the fatty tissue just beneath the skin, between the skin and muscle) before meals related to DM and hold for blood sugar less than 120 mg/deciliter (dl- one tenth of a liter). During a review of Resident 1 ' s MAR dated 5/2025, the MAR indicated Humulin R eight units was administered on the following dates and times. 1. 5/15/2025, at 11:30 a.m., with a blood sugar of 112 mg/dl. 2. 5/20/2025, at 5 p.m., with blood sugar of 110 mg/dl. 3. 5/24/2025, at 7 a.m., with a blood sugar of 103 mg/dl. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, and record review on 6/3/2025, at 10:20 a.m. with PIQIN 1, Resident 1 ' s MAR dated 5/2025 was reviewed. PIQIN 1 stated there were three incidences on 5/2025 MAR that Resident 1 received Humulin R eight units with a blood sugar below 120 mg/dl. PIQIN stated Humulin R should have been held as per physician order. PIQIN 1 stated Resident 1 can experience hypoglycemia (low blood guar) if physician order was not followed. PIQIN 1 stated nurses should read and follow the physician order. During an interview on 6/3/2025, at 11:14 a.m., with the RMN, the RMN stated nurses should follow the physician order. The RMN stated Humulin R is an insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) that lowers blood sugar. The RMN stated Resident 1 could experience hypoglycemia with Humulin R administration. During an interview on 6/4/2025, at 12:52 p.m., with the DON, the DON stated the facility failed to follow the physician order. The DON stated Resident 1 could have hypoglycemia because of the Humulin R administration and not following the physician order. During a review of facility ' s P&P, titled, Medication- Administration dated 7/1/2016, and last reviewed on 4/28/2025, the P&P indicated, I. Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner IV. The licensed nurse must know the following information about any medication they are administering: A. The drug's name. B. The drug's route of administration C. The drug's action D. The drug's indication for use and desired outcome E. The drug's usual dosage F. The drug's side effects and adverse effects G. Any precautions and special consideration VII. When administration of the drug is dependent upon vital signs or testing, the vital signs/testing will be completed prior to administration of the medication and recorded in the medical record (blood pressure, pulse, finger stick blood glucose monitoring). c. During a review of Resident 4 ' s admission Record, the admission Record indicated the facility admitted Resident 4 on 4/19/2022, with diagnoses that included unspecified atrial fibrillation (irregular heartbeat), generalized idiopathic epilepsy (a type of epilepsy where seizures originate in both sides of the brain simultaneously) and age-related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4 ' s Physician Order dated 4/19/2022, the Physician Order indicated Resident 4 may go out on therapeutic leave (TL-referred to as a leave of absence, allows residents of long-term care facilities to temporarily leave for non-medical reasons, like family visits or outings) with medications. During a review of Resident 4 ' s Physician Order, the Physician order indicated the following orders: 1. Gabapentin (medication used to treat epilepsy [muscle jerking, altered awareness, or changes in sensation or behavior] and nerve pain) capsule 100mg, give one capsule by mouth two times a day, ordered on 4/19/2022. 2. Lomotil (medication used to lower number of bowel movements) oral tablet 2.5 mg-0.025mg, one tablet by mouth three times a day, ordered on 11/3/2022. 3. Potassium chloride (KCL-medication used to prevent and treat low potassium levels in the body) 10 milliequivalent (meq-unit of measurement) by mouth daily, ordered on 11/23/2022. 4. Diltiazem extended release (ER-medication used to treat high blood pressure) capsule 120 mg, give one capsule by mouth daily, ordered on 3/20/2023. 5. Levothyroxine sodium (medication used to treat hypothyroidism [underactive thyroid]) 88 microgram (mcg-unit of measurement) by mouth daily, ordered on 4/1/2023. 6. Levetiracetam (medication used to treat epilepsy and seizures) oral tablet 250 mg, give two tablets by mouth every 12 hours, ordered on 4/14/2023. 7. Sulfasalazine (medication used to treat certain inflammatory conditions) tablet 1000 mg by mouth four times a day, ordered on 5/7/2024. 8. Lasix (medication that helps reduce excess fluid in the body) tablet 20 mg by mouth daily, ordered on 7/4/2024. 9. Metoprolol succinate (medication used to treat high blood pressure) extended release 100 mg every 12 hours, ordered on 7/11/2024. 10. Eliquis (medication used to treat blood clot) oral tablet 2.5 mg, give one tablet by mouth two times a day, ordered on 7/16/2024. 11. Ambien (medication that help individuals who have difficulty falling asleep or staying asleep) 5 mg, give one tablet by mouth at bedtime ordered on 12/21/2024. 12. Protonix (medication that reduces the amount of acid produced in the stomach) tablet 40mg, give one tablet by mouth in the morning, ordered on 4/11/2025. During a review of Resident 4 ' s MDS dated [DATE], the MDS indicated Resident 4 ' s cognitive skills for daily decision making were moderately impaired. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4 ' s H&P dated 4/24/2025, the H&P indicated Resident 4 had fluctuating capacity to understand and make decisions. During a review of Resident 4 ' s Progress Notes dated 5/2/2025, timed at 2:19 p.m., the Progress notes indicated on 5/2/2025, Resident 2 left the facility with FM 2. During a review of Resident 4 ' s Progress Notes dated 5/5/2025, timed at 6:06 a.m., the Progress Notes indicated on 5/5/2025, at 1:55 a.m., FM 2 arrived at the facility and took Resident 4 ' s belongings including all medications with narcotics (controlled substances [is a drug or chemical that is regulated by a government agency due to its potential for abuse and/or its impact on public health] that was used to treat pain). The Progress Notes indicated FM 2 refused to sign narcotic sheet out, and at 2:10 a.m., FM 2 left with all medications and narcotics against medical advice. During an interview on 6/4/2025, at 12:52 p.m., with the DON, the DON stated FM 2 threatened the nurses to give her (FM 2) all of Resident 4 ' s medications. The DON stated LVN 8, and RN 3 should not give the controlled medication to FM 2 without the physician ' s order. The DON stated LVN 8, or RN 3 should have notified the physician. During an interview on 6/4/2025, at 1:32 p.m., with the Administrator (ADM), the ADM stated nurses should not give the medication to FM 2 without a physician order. The ADM stated the nurses should have said no to FM 2. During an interview on 6/5/2025, at 7:54 a.m., with RN 3, RN 3 stated on 5/5/2025, early morning, LVN 8 called and notified her (RN 3) that FM 2 wanted to discharge Resident 4 and FM 2 was taking all of Resident 4 ' s belongings. RN 3 stated FM 2 was asking for all of Resident 4 ' s medication. RN 3 stated she (RN 3) called the DON, but the DON did not answer the phone, so she (RN 3) had informed LVN 8 to give all of Resident 4 ' s medication. RN 3 stated all medication were given to FM 2 including Ambien. During an interview on 6/5/2025, at 8:12 a.m., with LVN 8, LVN 8 stated on 5/5/2025 early am, FM 2 arrived in the facility and gathered all Resident 4 ' s belongings and requested all of Resident 4 ' s medication. LVN 8 stated she (LVN 8) notified RN 3 and RN 3 instructed her (LVN 8) to give FM 2 all of Resident 4 ' s medications. LVN 8 stated all of Resident 4 ' s medications were given to FM 2 without the physician order. LVN 8 stated she (LVN 8) cannot remember what medications were given and how many tablets were given. LVN 8 stated if she (LVN 8) had counted she (LVN 8) would have documented it. LVN 8 stated there were two controlled substances given to FM 2. During an interview on 6/5/2025, at 10:47 a.m., with the DON, the DON stated she (DON) was not called on the morning of 5/5/2025, that FM 2 was at the facility taking all of Resident 4 ' s medications. The DON stated she (DON) was concerned when the nurses gave the medications to FM 2. The DON stated the nurses should have called the security or the police. During a concurrent interview, and record review on 6/6/2025, at 10:08 a.m., with the Director of Staff Development (DSD), Resident 4 ' s Progress Notes dated 5/5/2025, was reviewed. The DSD stated there were no documented names of medications given to FM 2 in Resident 4 ' s medical record. The DSD stated there were two controlled drugs given to FM 2 which were Ambien and Lomotil. The DSD provided a list of itemized medication including number of tablets given to FM 2 as follows: (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Diltiazem 120 mg- 10 capsules 2. Eliquis 2.5 mg- 20 tablets 3. Gabapentin 100 mg - 16 tablets 4. KCL 10 meq. - 1 tablet 5. Lasix 20mg. - 10 tablets 6. Levetiracetam 250 mg - 14 tablet 7. Levothyroxine 88 mcg- 2 tablet 8. Metoprolol succinate 100 mg - 20 tablet 9. Protonix 40 mg - 4 tablet 10. Sulfasalazine 100 mg—40 tablets 11. Lomotil 2.5 mg-0.025 mg - 25 tablets 12. Ambien 5 mg – 6 tablets During an interview on 6/5/2025, at 10:47 a.m., with the DON, the DON stated the facility do not have a policy for therapeutic leave. During a review of facility ' s P&P titled, Transfer and Discharge dated 9/1/2023, and last reviewed on 4/28/2025, the P&P indicated, Disposition of Resident Drugs Upon discharge. A. Drugs which have been dispensed for individual resident use and are labeled in conformance with the state and federal law for outpatient use will be furnished to a resident by the Licensed Nurse upon discharge on the orders of the residents Attending Physician. B. Controlled Substances should not be release upon discharge of the resident unless permitted by the current state law governing the release of controlled substances and as authorized in writing by the resident ' s Attending Physician.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate and complete medical records for three of five sampled residents (Residents 4, 3, and 2) by: 1. Failing to document 12 medications provided to Resident 4 ' s Family Member 2 (FM2) when FM 2 requested the medications on 5/5/2025. 2. Failing to accurately document Resident 3 ' s behavior of throwing himself on the floor from 5/6/2025 to 5/24/2025. 3. Failing to document Resident 2 ' s vital signs (basic measurements that indicate how well your body is functioning) when Resident 2 had a fall incident on 5/21/2025. These failures had the potential to cause confusion in care and the medical records containing inaccurate documentation. Findings: a. During a review of Resident 4 ' s admission Record, the admission Record indicated the facility admitted Resident 4 on 4/19/2022, with diagnoses that included unspecified (unconfirmed) atrial fibrillation (irregular heartbeat), generalized idiopathic epilepsy (a type of epilepsy where seizures originate in both sides of the brain simultaneously) and age-related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 4 ' s Physician Order dated 4/19/2022, the Physician Order indicated Resident 4 may go out on therapeutic leave (TL-referred to as a leave of absence, allows residents of long-term care facilities to temporarily leave for non-medical reasons, like family visits or outings) with medications. During a review of Resident 4 ' s Physician Order, the Physician order indicated the following orders: 1. Gabapentin (medication used to treat epilepsy [muscle jerking, altered awareness, or changes in sensation or behavior] and nerve pain) capsule 100 milligram (mg- metric unit of measurement, used for medication dosage and/or amount), give one capsule by mouth two times a day, ordered on 4/19/2022. 2. Lomotil (medication used to lower number of bowel movements) oral tablet 2.5 mg-0.025mg, one tablet by mouth three times a day, ordered on 11/3/2022. 3. Potassium chloride (KCL-medication used to prevent and treat low potassium levels in the body) 10 milliequivalent (meq-unit of measurement) by mouth daily, ordered on 11/23/2022. 4. Diltiazem (medication used to treat high blood pressure) extended-release capsule 120 mg, give one capsule by mouth daily, ordered on 3/20/2023. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Levothyroxine sodium (medication used to treat hypothyroidism [underactive thyroid]) 88 microgram (mcg-unit of measurement) by mouth daily, ordered on 4/1/2023. 6. Levetiracetam (medication used to treat epilepsy and seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) oral tablet 250 mg, give two tablets by mouth every 12 hours, ordered on 4/14/2023. 7. Sulfasalazine (medication used to treat certain inflammatory conditions) tablet 1000 mg by mouth four times a day, ordered on 5/7/2024. 8. Lasix (medication that helps reduce excess fluid in the body) tablet 20 mg by mouth daily, ordered on 7/4/2024. 9. Metoprolol succinate (medication used to treat high blood pressure) extended release 100 mg, every 12 hours, ordered on 7/11/2024. 10. Eliquis (medication used to treat blood clot) oral tablet 2.5 mg, give one tablet by mouth two times a day, ordered on 7/16/2024. 11. Ambien (medication that help individuals who have difficulty falling asleep or staying asleep) 5 mg, give one tablet by mouth at bedtime ordered on 12/21/2024. 12. Protonix (medication that reduces the amount of acid produced in the stomach) tablet 40 mg, give one tablet by mouth in the morning, ordered on 4/11/2025. During a review of Resident 4 ' s Minimum Data Set (MDS-a resident assessment tool), dated 1/28/2025, the MDS indicated Resident 4 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. During a review of Resident 4 ' s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 4/24/2025, the H&P indicated Resident 4 had fluctuating capacity to understand and make decisions. During a review of Resident 4 ' s Progress Notes dated 5/2/2025, timed at 2:19 p.m., the Progress notes indicated on 5/2/2025, Resident 2 left the facility with FM 2. During a review of Resident 4 ' s Progress Notes dated 5/5/2025, timed at 6:06 a.m., the Progress Notes indicated on 5/5/2025, at 1:55 a.m., FM 2 arrived at the facility and took Resident 4 ' s belongings including all medications with controlled substances (is a drug or chemical that is regulated by a government agency due to its potential for abuse and/or its impact on public health). The Progress Notes indicated FM 2 refused to sign the narcotic sheet (controlled substances sheet) out, and at 2:10 a.m., FM 2 left with all medication against medical advice. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/5/2025, at 7:54 a.m., with RN 3, RN 3 stated on 5/5/2025, early morning, LVN 8 called and notified her (RN 3) that FM 2 wanted to discharge Resident 4 and FM 2 was taking all of Resident 4 ' s belongings. RN 3 stated FM 2 was asking for all of Resident 4 ' s medication. RN 3 stated she (RN 3) called the Director of Nursing (DON), but the DON did not answer the phone, so she (RN 3) had informed LVN 8 to give all of Resident 4 ' s medication. RN 3 stated all medication were given to FM 2 including Ambien. During an interview on 6/5/2025, at 8:12 a.m., with LVN 8, LVN 8 stated on 5/5/2025 early am, FM 2 arrived in the facility and gathered all Resident 4 ' s belongings and requested all of Resident 4 ' s medication. LVN 8 stated she (LVN 8) notified RN 3 and RN 3 instructed her (LVN 8) to give FM 2 all of Resident 4 ' s medications. LVN 8 stated all of Resident 4 ' s medication was given to FM 2 without the physician order. LVN 8 stated she (LVN 8) cannot remember what medication was given and how many tablets was given. LVN 8 stated if she (LVN 8) had counted she (LVN 8) would have documented it. LVN 8 stated there were two controlled medications given to FM 2. During a concurrent interview, and record review on 6/6/2025, at 10:08 a.m., with the Director of Staff Development (DSD), Resident 4 ' s Progress Notes dated 5/5/2025, was reviewed. The DSD stated there were no documented names of medications given to FM 2 in Resident 4 ' s medical record. The DSD stated there were two controlled drugs given to FM 2 which are Ambien and Lomotil. The DSD provided a list of itemized medication including number of tablets given to FM 2 as follows: 1. Diltiazem 120 mg- 10 capsules 2. Eliquis 2.5 mg- 20 tablets 3. Gabapentin 100 mg - 16 tablets 4. KCL 10 meq. - 1 tablet 5. Lasix 20mg. - 10 tablets 6. Levetiracetam 250 mg - 14 tablets 7. Levothyroxine 88 mcg- 2 tablets 8. Metoprolol succinate 100 mg - 20 tablets 9. Protonix 40 mg - 4 tablets 10. Sulfasalazine 100 mg—40 tablets 11. Lomotil 2.5 mg-0.025 mg - 25 tablets 12. Ambien 5 mg – 6 tablets (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/5/2025 at 10:47 a.m., with the DON, facility ' s policy and procedure (P&P), titled, Documentation-Nursing, dated 3/20/2025, and last reviewed on 4/28/2025, the P&P indicated, Nursing documentation will be concise, clear, pertinent, and accurate. Nurse's notes addressing the resident leaving the facility will document when and with whom, and time of return, along with any medications sent. Documentation will be completed by the end of the assigned shift. The DON stated medication given to FM 2 should have been documented for completeness of medical record. During a review of facility ' s P&P titled, Transfer and Discharge dated 9/1/2023, and last reviewed on 4/28/2025, the P&P indicated, Disposition of Resident Drugs Upon discharge. A. Drugs which have been dispensed for individual resident use and are labeled in conformance with the state and federal law for outpatient use will be furnished to a resident by the Licensed Nurse upon discharge on the orders of the residents Attending Physician. B. Controlled Substances should not be release upon discharge of the resident unless permitted by the current state law governing the release of controlled substances and as authorized in writing by the resident ' s Attending Physician. b. During a review of Resident 3 ' s admission Record, the admission Record indicated the facility admitted Resident 3 on 1/17/2025, with diagnoses that included Parkinson ' s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), unspecified Alzheimer ' s Disease (a disease characterized by a progressive decline in mental abilities), muscle weakness and age-related osteoporosis. During a review of Resident 3 ' s H&P, dated 4/18/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3 ' s MDS, dated [DATE], the MDS indicated Resident 3 ' s cognitive skills for daily decision making severely impaired. The MDS indicated Resident 3 was dependent to staff for activities of daily living (ADL- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 3 ' s Progress Notes dated 5/25/2025, timed at 2:50 p.m., the Progress Notes indicated on 5/25/2025, at 2 p.m., Activity Staff reported that Resident 3 was sitting on the floor mat next to his (Resident 3) bed with no bruises, no changes in level of consciousness and vital signs was stable. The Progress Notes indicated at 2:10 p.m. FM 2 was informed and requested General Acute Care Hospital (GACH) transfer. The Progress notes indicated at 2:15 p.m., the physician was notified and agreed for GACH transfer. During a concurrent interview, and record review on 6/3/2025, at 9:54 a.m., with Care Planner 1 (CP 1), Resident 3 ' s Progress Notes dated 5/6/2025 to 5/24/2025 was reviewed. The Progress Notes indicated from 5/6/2025 to 5/10/2025, 5/13/2025, and 5/15/2025 to 5/24/2025, LVN ' s 5, 6, and 7 documented that Resident 3 was observed with behavior of throwing himself (Resident 3) on the floor and cannot stay in the room unattended. CP 1 stated the were no reported behavior that Resident 3 throws himself on the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555579	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ararat Nursing Facility	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, and record review on 6/3/2025, at 11:14 a.m., with the RMN, Resident 3 ' s Progress Notes dated 5/6/2025 to 5/25/2025, and IDT dated 5/26/2025 was reviewed. The RMN stated LVNs 5, 6, and 7 documented Resident 3 ' s behavior of throwing himself (Resident 3) on the floor almost daily, 16 times from 5/6/2025 until 5/24/2025 and on 5/25/20205, Resident 3 had a fall. The RMN stated she (RMN) was not informed of Resident 3 ' s behavior and knows that Resident 3 do not have that behavior. The RMN stated nurses were possibly copying and pasting other nurses ' documentation. During an interview on 6/4/2025, at 12:52 p.m. with the DON, the DON stated Resident 3 had behavior of throwing himself (Resident 3) on the floor initially but not for 14 days in a row. The DON stated it was a major error on the nurse ' s part. The DON stated the nurses were lazy and not paying attention to their documentation. The DON stated the facility failed to follow policy for documentation and to not copy and paste other nurses ' documentation. During an interview on 6/4/2025, at 3:02 p.m., with LVN 6, LVN 6 stated he (LVN 6) did not observe Resident 3 ' s behavior of throwing himself (Resident 3) on the floor. LVN 6 stated he (LVN 6) did copy and paste previous nurses ' documentation. LVN 6 stated it was his (LVN 6) fault that he (LVN 6) should have document only what was observed. LVN 6 stated the importance of accurate documentation was to record what happen and what was done for that shift. During an interview on 6/4/2025, at 3:09 p.m., with LVN 7, LVN 7 stated she (LVN 7) sometimes copy and paste other nurses ' documentation. LVN 7 stated nurses should only documented what was observed and was what done for the resident. c. During a review of Resident 2 ' s admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included atherosclerotic heart disease (the arteries that supply blood to your heart become hardened and narrowed due to the buildup of plaque), Alzheimer ' s Disease and age-related osteoporosis. During a review of Resident 2 ' s H&P, dated 3/1/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 ' s cognitive skills for daily decisions was moderately impaired. The MDS indicated Resident 2 needed maximum assistance from staff for oral hygiene, showering, dressing, personal hygiene and transfer. During a review of Resident 2 ' s Progress Notes dated 5/21/2025, timed at 10:56 p.m., the Progress Notes indicated on 5/21/2025, at 9:30 p.m., CNA 5 reported that Resident 2 was found on the floor. The Progress Notes indicated Resident 2 complained of right hip pain and unable to move her (Resident 2) right leg. The Progress Notes indicated the physician was notified with order to transfer Resident 2 to GACH via 911. During an interview on 5/30/2025, at 9:13 a.m., with LVN 3, LVN 3 stated when she (LVN 3) responded to CNA 5 ' s report that Resident 2 was on the floor, she (LVN 3) took Resident 2 ' s vital signs. LVN 3 stated she must have forgotten to document Resident 2 ' s vital signs. During an interview on 6/3/2025, at 8:35 a.m. with RN 2, RN 2 stated he (RN 2) did not check Resident 2 ' s vitals signs during the fall. RN 2 stated checking vitals signs was LVN ' s responsibility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555579	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ararat Nursing Facility	15099 Mission Hills Road Mission Hills, CA 91345

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/3/2025, at 11:14 a.m., with the RMN, the RMN stated Resident 2 ' s vitals signs on 5/21/2025 at 9:30 p.m., was not documented in Resident 2 ' s Progress Notes and Vital Signs Log. The RMN stated vitals signs should be documented in Resident 2 ' s medical record as it is part of an assessment after a change in condition. During an interview on 6/4/2025, at 12:52 p.m., with the Director of Nursing (DON), the DON stated the facility failed to document Resident 2 ' s vital signs. The DON stated the nurses should check and documented vital signs every after change of condition. During a concurrent interview and record review on 6/5/2025, at 10:467 a.m., with the DON, facility ' s P&P, titled, Documentation-Nursing, dated 3/20/2025 and last reviewed on 4/28/2025, the P&P indicated, Nursing documentation will be concise, clear, pertinent, and accurate. Narrative charting, as outlined in specific policies and procedures, will be used for initial treatments or procedures. Documentation for subsequent and/or routine care and procedures may be completed by exception. Checklists, flow charts, and other documentation tools will be used as appropriate. Documentation will be completed by the end of the assigned shift. The DON stated nurses should document accurately because it ' s the facility policy. During a review of facility ' s P&P titled, Change of Condition Notification, dated 1/1/2017, and last reviewed on 4/28/2025, the P&P indicated, The Licensed Nurse will assess the resident's change of condition and document the observations and symptoms. VI. Documentation A. A Licensed Nurse will document the following: i. Date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes.