

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 06/27/2025
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 - Immediate jeopardy to resident health or safety</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>(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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of four sample residents (Resident 1), who had moderate impaired cognition (a stage where individuals experience noticeable and significant difficulties in functions like memory, language, and problem-solving, affecting their ability to manage daily activities independently), was free from sexual abuse (any sexual activity that occurs without consent [permission]), by Resident 2 (Resident 1's roommate) on 6/20/2025 by failing to: 1. Protect Resident 1 from Resident 2 when Certified Nursing Assistant (CNA) 1 and Licensed Vocational Nurse (LVN) 1 witnessed Resident 2, topless with breasts uncovered, was at the head of Resident 1's bed leaning on top of Resident 1 who was lying on her (Resident 1) bed. Resident 2 was rubbing her (Resident 2) exposed breasts against Resident 1's chest while Resident 2 was sucking Resident 1's chin causing it (Resident 1's chin) to be red. 2. To identify the potential risks of Resident 2's sexually inappropriate behavior (masturbatory behavior) to other residents (in general). 3. Prevent sexual abuse by ensuring facility licensed staff monitored and documented Resident 2's sexually inappropriate behavior (masturbatory behavior) and develop interventions and implement interventions to prevent abuse to other residents (in general). 4. Identify and evaluate if Resident 1 had the capacity to consent (when someone understands what they are being asked to do, and they give their permission clearly and freely without being pressured) to perform sexual activity with Resident 2 or other residents to prevent sexual abuse. 5. Assess Resident 1 for possible injuries after the sexual abuse incident on 6/20/2025 at around 4:50 a.m. in accordance with the facility's policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program, with review date of 4/28/2025, indicating, A Licensed Nurse assesses the resident (alleged victim) for possible injuries. 6. Follow its P&P titled, Abuse Prevention and Prohibition Program, with review date of 4/28/2025, indicating, Each resident has the right to be free from abuse. The Facility has zero-tolerance for abuse. Staff must not permit anyone to engage in . sexual . abuse. These deficient practices resulted in Resident 1 being subjected to sexual abuse by Resident 2 while under the care of the facility. CNA 1 stated Resident 1 looked in panic and in shock during the incident. CNA 3 went to Resident 1 to offer to change Resident 1 (who refused to be changed by CNA 1) after the sexual abuse incident stated Resident 1 started to become agitated, shaking, and looks nervous. On 6/20/2025 at 10:24 a. m., the facility sent Resident 2 to General Acute Care Hospital (GACH) 1 for psychological evaluation (a comprehensive assessment conducted by a mental health professional to understand an individual's psychological state, including their thoughts, feelings, behaviors, and personality). Based on the reasonable person concept (refers to a tool to assist the survey team's assessment of the severity level of negative, or potentially negative, psychosocial outcome of the deficiency may have had on a reasonable person in the president's position), due to Resident 1's moderately impaired cognitive skills, an individual subjected to abuse may have psychological (mental or emotional) effects including feelings of hopelessness (a feeling or state of despair or lack of hope), helplessness (the belief that there is nothing that anyone can do to improve a bad situation), and humiliation (the feeling of being ashamed or losing respect for yourself). On 6/25/2025 at 5:14 p.m. while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) under 42 CFR S483.12 Freedom from Abuse, Neglect (failed to care for properly), and Exploitation (illegal or improper use of a person's resources) in the presence of the Administrator (ADM), Director of Nursing (DON), and the Risk Manager Nurse (RMN) due to the facility's failure to protect Resident 1's right to be free from sexual abuse on 6/20/2025 at around 4:50 a.m. On 6/27/2025 at 4:32 p.m., the ADM provided the SSA with an acceptable IJ Removal Plan (a detailed plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation). On 6/27/2025 at 5:12 p.m., while onsite at the facility and after verifying and confirming the facility's implementations of the IJ Removal plan through observations, interviews, and record reviews, the SSA removed the IJ situation in the presence of the ADM, DON, Assistant DON (ADON), RMN, and DSD (Director of Staff Development). The acceptable IJ Removal Plan included the following summarized actions: 1. On 6/20/2025 at 4:50 a.m., CNA 1 found Resident 2 on top of Resident 1 and CNA 1 separated Resident 1 and Resident 2 (both are still in the same room). LVN 2 monitored Resident 1 to prevent reoccurrence. 2. On 6/20/2025 at about 5 a.m., CNA 2 and CNA 3 alternated being in Resident 1 and Resident 2's room to assure the safety of Resident 1 and prevent</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 4/18/2023 with diagnoses including atherosclerotic heart disease of native coronary artery without angina pectoris (clogged heart arteries without chest pain) and hypertension (high blood pressure).</p> <p>During a review of Resident 1's Initial History and Physical, dated 4/11/2025, the Initial History and Physical indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 6/1/2025, the MDS indicated Resident 1 was moderately impaired with thought process and required substantial assistance from staff to complete activities of daily living (ADLs &ndash; activities such as bathing, dressing, and toileting a person performs daily).</p> <p>During a review of Resident 1's Progress Notes, dated 6/20/2025 at 10:22 a.m., the note indicated that at 4:50 a.m. CNA 1 reported to LVN 1 that Resident 2 was found on top of Resident 1 with Resident 2's breasts exposed and rubbed against Resident 1 and Resident 2 was sucking Resident 1's chin. The note indicated LVN 1 noted a red-mark color on Resident 1's chin as a result from Resident 2's sucking Resident 1's chin. The note indicated RN 1 notified the Physician.</p> <p>During a review of Resident 2's admission Record, the admission Record indicated the facility originally admitted Resident 2 on 1/22/2021 and readmitted on [DATE] with diagnoses including atherosclerotic heart disease of native coronary artery without angina pectoris and hypertension.</p> <p>During a review of Resident 2's Initial History and Physical, dated 1/30/2025, the Initial History and Physical indicated Resident 2 had fluctuating capacity to understand and make decisions due to dementia (decline in mental abilities, like memory and thinking, that is severe enough to interfere with daily life).</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was moderately impaired with thought process and required substantial to partial assistance from staff to complete ADLs.</p> <p>During a review of Resident 2's Care Plan Report, dated 9/17/2024, the Care Plan Report indicated Resident 2 exhibited masturbatory behavior.</p> <p>During a review of Resident 2's Progress Notes, dated 6/20/2025 at 4:50 a.m., the note indicated that at 4:50 a.m. CNA 1 reported to LVN 1 that Resident 2 was found on top of Resident 1 with Resident 2 breasts exposed and rubbed against Resident 1 and Resident 2 was sucking Resident 1's chin. The note indicated LVN 1 noted a red-mark color on Resident 1's chin as a result from Resident 2's sucking Resident 1's chin. The note indicated RN 1 notified the Physician. The note indicated on 6/20/2025 at 10:24 a.m., the Physician gave an order to transfer Resident 2 to GACH 1 for further evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/23/2025 at 11:13 a.m., with LVN 1, LVN 1 stated that while LVN 1 was in nurse's station on 6/20/2025 at &ldquo;around 4:50 a.m.,&rdquo; CNA 1 was standing at the door of Residents 1 and 2's room (near the nurse's station) and reported to LVN 1 that Resident 2 was on top of Resident 1. CNA 1 stated Resident 2's blouse was down to her (Resident 2's) waist, and Resident 2 rubbed her (Resident 2) uncovered breasts against Resident 1's chest. LVN 1 stated CNA 1 reported Resident 2 was sucking Resident 1's chin. LVN 1 stated she (LVN 1) immediately went to Resident 1 and 2's room and observed that Resident 2 was still on top of Resident 1 and LVN 1 asked Resident 2 to get away from Resident 1 and to return to Resident 2's bed. LVN 1 stated Resident 2 started to get a little agitated and Resident 2 started to give a hand gesture to LVN 1 to go away. LVN 1 stated Resident 1's chin was red from Resident 2's sucking. LVN 1 stated she notified RN 1 right away. LVN 1 stated that when she (LVN 1) got hired since 2/2025, LVN 1 already knew and observed Resident 2's behavior of patting and touching her (Resident 2) own private area and touching her (Resident 2) own breasts. LVN 1 stated staff in the unit were aware of Resident 2's behavior. LVN 1 stated this was considered as sexual abuse due to inappropriate behavior of Resident 2 towards Resident 1 by rubbing her (Resident 2) breasts to Resident 1's chest and sucking Resident 1's whole chin which left a redness on Resident 1's chin.</p> <p>During an interview on 6/23/2025 at 11:38 a.m. with CNA 1, CNA 1 stated that she (CNA 1) found Resident 2 on top of Resident 1 with Resident 2's blouse down to her (Resident 2) waist, rubbing her (Resident 2) breasts against Resident 1, sucking Resident 1's chin. CNA 1 stated she (CNA 1) reported the incident to LVN 1 right away. CNA 1 stated this was considered as sexual abuse because Resident 1 did not give any consent to Resident 2 because Resident 1 was confused.</p> <p>During an interview on 6/23/2025 at 12:29 p.m. with CNA 4, CNA 4 stated Resident 2 usually touches herself and CNA 4 usually provides privacy to Resident 2.</p> <p>During an interview on 6/24/2025 at 6:29 a.m. with CNA 1 in Resident 1 and 2's room, CNA 1 stated she (CNA 1) was in another resident's (name not indicated) room (a room across Residents 1 and 2's room) and heard a bed-squishing noise prompting her (CNA 1) to check and go to the door of Residents 1 and 2's room. CNA 1 was observed demonstrating how Resident 2 was standing on the right side on the top part of Resident 1's bed. CNA 1 stated Resident 2 was rubbing her (Resident 2) exposed breasts to Resident 1's chest and sucking Resident 1's chin. CNA 1 stated during that time CNA 1 observed Resident 1 looked panic and shocked.</p> <p>During an interview on 6/24/2025 at 6:39 a.m. with CNA 3, CNA 3 stated she was assigned to care for Resident 1 after the sexual abuse incident on 6/20/2025 at around 4:50 a.m. CNA 3 stated she (CNA 3) offered to change Resident 1 and observed Resident 1 was agitated holding her (Resident 1) hands close to her (Resident 1) chest, very nervous, shaking, and refusing to be changed. CNA 3 stated Resident 1 later on agreed to be changed after explanation that she (Resident 1) needed to be changed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/25/2025 at 11:13 a.m. with RN 2, Resident 2's care plan titled, "Exhibiting Masturbatory Behavior," dated 9/17/2024, all other current care plans since admission, Medication Administration Record (MAR), and Progress Notes from 5/8/2024 to 6/20/2025 were reviewed. RN 2 stated there was no intervention to monitor Resident 2's masturbatory behavior based on Resident 2's care plan and no behavioral monitoring found in Resident 2's MAR and progress notes. RN 2 stated Resident 2's care plan was not assessed and revised to indicate how Resident 2's masturbatory behavior will potentially affect other residents. RN 2 stated had the facility created a care plan on how Resident 2's masturbatory behavior will potentially affect other residents; this incident could have been prevented. RN 2 stated that there was no assessment or documentation about Resident 2's masturbatory behavior during a review of Resident 2's progress notes from 5/8/2024 to 6/20/2025. RN 2 stated that as a result Resident 2's behavior was not monitored, and Resident 2 sexually abused her roommate (Resident 1).</p> <p>During a concurrent interview and record review on 6/25/2025 at 1:05 p.m. with Resident Care Planner (RCP) 1, Resident 2's care plan titled, "Exhibiting Masturbatory Behavior," dated 9/17/2024, was reviewed. RCP 1 stated she (RCP) was the author of the care plan, and a nurse (could not remember who the nurse was) reported that Resident 2 had an episode of masturbation behavior (cannot remember the date). RCP 1 stated monitoring Resident 2's behavior was not included in Resident 2's care plan interventions. RCP 1 stated Resident 2's behavior should be monitored to know if the interventions are effective. RCP 1 stated there was no intervention included to identify the risk of Resident 2's behavior to other residents. RCP 1 stated it was important to include how Resident 2's behavior will affect other residents and possibly this sexual abuse incident could have been prevented if there was a proper intervention for Resident 2.</p> <p>During a concurrent interview and record review on 6/24/2025 at 9:56 a.m. with Risk Manager Nurse (RMN), Resident 1's Progress Notes dated between 6/20/2025 to 6/24/2025 and vital signs (measurements of the body's most basic functions) dated 6/20/2025, were reviewed. Resident 2's Progress Notes dated between 6/20/2025 and vital signs dated 6/20/2025, were also reviewed. RMN stated there was no documented evidence that assessment was done, and vital signs were taken after the sexual abuse incident on 6/20/2025 at "around 4:50 a.m." for Resident 1 and Resident 2. RMN stated Resident 1's condition must be monitored after the sexual abuse incident for 72 hours every shift, but it was not done.</p> <p>During a telephone interview on 6/25/2025 at 10:11 a.m. with Family Member (FM) 1, FM 1 stated Resident 1 was a conservative person so this sexual abuse incident on 6/20/2025 at around 4:50 a.m. will destroy, traumatize, and mentally damage Resident 1. FM 1 stated Resident 1 will lose a lot of sleep, will not know what to do, feel victimize, and will feel her life will be ruined just like other sexual victims. FM 1 stated the family members (FM 1, FM 2, and FM 3) were shocked and traumatized. FM 1, FM 2, and FM 3 cried, felt angry and felt guilty by choosing this facility. FM 1 stated FM 1, FM 2 and FM 3 lost sleep, felt anxious, and uneasy when they found out about Resident 1's sexual abuse incident on 6/20/2025 at around 4:50 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/25/2025 at 11:13 a.m. with Registered Nurse (RN) 2, Resident 1's Progress Notes, dated between 6/20/2025 to 6/24/2025 and vital signs dated 6/20/2025 were reviewed. Resident 2's Progress Notes dated between 6/20/2025 and vital signs dated 6/20/2025, were also reviewed. RN 2 stated there was no head-to-toe assessments (a systematic and comprehensive physical examination that evaluates all major body systems, from the head to the feet, to determine a resident's overall health status) and no vital signs were taken for Resident 1 and Resident 2 after the sexual abuse incident last 6/20/2025 at 4:50 a.m. RN 2 stated that staff must do a head-to-toe assessment, check vital signs and monitor Resident 1 and Resident 2 (was discharged to GACH 1 on 6/20/2025 at 10:24 a.m.) every shift for 72 hours every shift to know how this incident could affect them (Resident 1 and Resident 2). RN 2 stated it was important to monitor Resident 1 closely.</p> <p>During an interview on 6/25/2025 at 2:26 p.m. with CNA 6, CNA 6 stated she (CNA 6) was the regular CNA assigned in the morning for Resident 2 and had been taking care of her (Resident 2) since she (Resident 2) was admitted. CNA 6 stated she (CNA 6) observed Resident 2 will call her (CNA 6) inside Resident 2's room and will start patting her (Resident 2) private area and this happened three times last week on different days before the incident that happened on 6/20/2025 at around 4:50 a.m. CNA 6 stated she (CNA 6) reported those observations to LVN 4 for LVN 4 to talk to Resident 2 to stop doing those inappropriate sexual behavior (patting the vagina).</p> <p>During an interview on 6/25/2025 at 2:34 p.m. with LVN 4, LVN 4 stated she was the regular charge nurse for Resident 1 and Resident 2. LVN 4 stated CNA 6 reported about two to three times (dates not indicated) that Resident 2 was patting her abdomen but did not document anything or did not report to anyone because LVN 4 did not think it was a sexual behavior because Resident 2 was patting her abdomen. LVN 4 later on stated CNA 6 reported to her (LVN 6) that Resident 2 was patting her (Resident 2) private area (vagina) but cannot imagine Resident 2 doing that. LVN 4 stated she (LVN 4) did not document and did not report Resident 2's inappropriate sexual behaviors (patting the vagina) to the RN and Physician.</p> <p>During a concurrent interview and record review on 6/26/2025 at 4:01 p.m. with the DON and RMN, Resident 1's admission record, history and physical, MDS (dated 6/1/2025), care plans (dated 4/11/2024 to 6/9/2025) and progress notes (dated 6/2/2025 to 6/23/2025) were reviewed. The DON stated Resident 1's cognition was moderately impaired and was diagnosed with dementia. The DON stated Resident 1's History and Physical, dated 4/11/2025, indicated Resident 1 did not have the capacity to make decisions. The DON stated she (DON) observed Resident 1 could nod her head for yes or no and could only answer a certain question (did not indicate what question). The DON and RMN stated Resident 1 was unable to give consent for any sexual activity.</p> <p>During an interview on 6/26/2025 at 4:35 p.m. with the DON, the DON stated the facility failed to provide safety for Resident 1 and knowing that Resident 2's behavior was exhibited since 9/2024. The DON stated there were no monitoring and no documentation of Resident 2's sexually inappropriate behaviors (masturbatory behaviors). The DON stated there was lack of documentation and reporting. The DON stated this resulted to Resident 2 sexually assaulted Resident 1.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of the current facility-provided policy and procedure titled, "Abuse Prevention and Prohibition Program," with review date of 4/28/2025, the policy and procedure indicated, "The Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to protect residents. Each resident has the right to be free from abuse. The Facility has zero-tolerance for abuse. Staff must not permit anyone to engage in sexual abuse. The Facility is committed to protecting residents from abuse by anyone, including but not limited to other residents. Resident assessments and care planning are performed to monitor resident needs and address behaviors that may lead to conflict. The Administrator then acts to ensure the following steps are taken: ii. A Licensed Nurse assesses the resident (alleged victim) for possible injuries."</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a care plan was created for a resident who was high risk for fall for one of four sampled resident (Resident 2). This deficient practice had the potential to a delay in/or lack of delivery of care and services to Resident 2. Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility originally admitted Resident 2 on 1/22/2021 and readmitted on [DATE] with diagnoses including atherosclerotic heart disease of native coronary artery without angina pectoris and hypertension. During a review of Resident 2's Initial History and Physical, dated 1/30/2025, the Initial History and Physical indicated Resident 2 had fluctuating capacity to understand and make decisions due to dementia (decline in mental abilities, like memory and thinking, that is severe enough to interfere with daily life). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 5/25/2025, the MDS indicated Resident 2 was moderately impaired with thought process and required substantial to partial assistance from staff to complete activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 2's Fall Risk Assessments, dated 3/4/2025, 6/2/2025, and 6/8/2025, the Fall Risk Assessments indicated Resident 2 on 3/4/2025 had a total score of 22, on 6/22/2025 had a total score of 22, and on 6/8/2025 a total score of 24. A total score above 10 represents high risk for falls. During a concurrent interview and record review on 6/26/2025 at 10:44 a.m. with Registered Nurse (RN) 2, Resident 2's Fall Risk assessment dated [DATE], 6/2/2025, and 6/8/2025 were reviewed. Resident 2's Care Plan was reviewed. RN 2 stated that Resident 2's Fall Risk Assessment score was 22 since 3/4/2025. RN 2 stated any score more than 10 means a resident is a high risk for fall. RN 2 stated that Resident 2 did not have a care plan on high risk for fall before Resident 2 had a fall incident last 6/8/2025. RN 2 stated Resident 2 should have a high risk for fall care plan and proper interventions like highlighted Resident 2's name by the door, low bed position, frequent visual check, call light within reach, and therapy so that the staff were aware that Resident 2 was a high risk for fall and proper fall preventions were in place. During a review of the facility policy and procedure titled, Care Planning, last review date 4/28/2025, the policy and procedure indicated, To ensure that a comprehensive person-centered care plan is developed for each resident based on their individual assessed needs.</p>		