

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 07/08/2025
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)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (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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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure residents were free from unnecessary psychotropic medication (medications that affect the mind, emotions, and behavior) for one of three sampled residents (Residents 1) by failing to:1. Provide ongoing re-evaluation of the need for psychotropic medication by failing to ensure PRN (given as needed or requested) risperidone (Risperdal-a psychotropic medication used to treat mental health conditions such as schizophrenia [(a mental illness that is characterized by disturbances in thoughts)] was ordered with an end date (time at which a medication will no longer be dispensed and will be required to be re-prescribed).2. Provide ongoing re-evaluation of the need for psychotropic medication by failing to monitor for adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status) of risperidone. 3. Ensure as needed (PRN) risperidone was prescribed for a specific, diagnosed condition. These deficient practices had the potential to result in the administration of unnecessary psychotropic medication and placed Residents at risk for decline in physical functioning, and injury.Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 1/6/2023 with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), anxiety disorder (feeling of anxiousness that affects daily life), history of repeated falls.During a review of Resident 's M1inimum Data Set (MDS - resident assessment tool), dated 5/28/2025, the MDS indicated Resident 1 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS further indicated Resident 1was dependent on staff for bathing and required moderate assistance with personal hygiene, toileting hygiene, lower body dressing. During a review of Resident 1's Care Plan (CP), dated 7/2/2025, the CP indicated Resident 1 was receiving antipsychotic drug therapy (Risperdal/PRN) and was at risk for toxicity and falls. The CP interventions indicated to obtain consent, monitor resident for common side effects such as sedation (a state of sleepiness caused by certain drugs), confusion, restlessness, and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares and loss of consciousness).During a review of Resident 1's Care Plan (CP), dated 7/2/2025, the CP indicated Resident 1 was receiving PRN risperidone and was at risk for toxicity and falls. The CP interventions indicated to obtain consent, monitor resident for common side effects such as sedation (a state of sleepiness caused by certain drugs), confusion, restlessness, and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares and loss of consciousness).1.a During a concurrent interview and record review on 7/7/2025 at 11:48 a.m. with Registered Nurse (RN) 1, Resident 1's Order Summary Report was reviewed. The Order Summary indicated on 7/1/2025, Resident 1 was prescribed Risperidone tablet 1milligram (mg-unit of measurement), 1 tablet by mouth as needed for agitation manifested by aggressive behavior towards staff at bedtime. RN 1 stated the order for Risperidone did not have an end date. RN 1 stated antipsychotic medications such as Risperidone used in as needed bases should have an end date. RN 1 further stated the end date was indicated to stop the administration of the medication and allow the physician to review resident's progress and determine if the medication is necessary to continue. RN 1 stated the failure had the potential for Resident 1 to receive medication that was not indicated and experience side effects. During an interview on 7/2/2025 at 12:06 p.m. with the Director of Nursing (DON), the DON stated Resident 1's risperidone order should have had an end date after 14 days of the initiation of the order. The DON stated facility failed to obtain an end date for Resident 1's Risperidone order. The DON further stated the failure had the potential for Resident 1 to receive unnecessary medication negatively affecting Resident 1's well-being. During a review of the facility-provided policy and procedure (P&P) titled, Psychotropic Medication Use, last reviewed on 01/27/2025, the P&P indicated, Psychotropic also described as 'psycho-pharmacologic medication,' 'psychoactive,' or 'psychotherapeutic' medications are drugs that affect brain activities associated with mental processes and behavior. PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the Attending Physician/LHP evaluates the resident, in person, for the appropriateness of that medication.1b. During a concurrent interview and record review on 7/7/2025 at 11:48 a.m. with Registered Nurse (RN) 1, Resident 1's Medication Administration Record (MAR), dated 7/2025 was reviewed. The Order Summary indicated on 7/1/2025, Resident 1 was prescribed a risperidone tablet 1milligram (mg-unit of measurement), 1 tablet by</p>		