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	02/04/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to ensure the Medical Doctor (MD) and the Resident Representative (RR) of one of three sampled residents (Resident 1) were notified when on 1/14/2026 at 3 a.m. Certified Nursing Assistant (CNA) 1 who was assigned to Resident 1 allegedly tied Resident 1's hands together at the wrist with a scarf while Resident 1 was in her bed in her (Resident 1) room.This deficient practice had the potential to negatively affect the care and services provided to Resident 1.Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 8/16/2025 with diagnosis including dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), muscle weakness (general), and abnormalities of gait (manner of walking) and mobility (ability to move). During a review of Resident 1's Physician History and Physical (H&P- a process used by doctors to understand residents' health which combines medical history and a physical examination), dated 9/5/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Fall Risk Assessment (a process used by healthcare providers to determine a resident's likelihood of falling), dated 12/8/2025, the Fall Risk Assessment indicated Resident 1's fall risk score was 21 meaning Resident 1 was a high risk for fall. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/8/2025, the MDS indicated Resident 1 rarely understood and was rarely understood. The MDS indicated Resident 1 was dependent on staff for showering, required substantial assistance (helper does more than half the effort) with upper body dressing, and required partial assistance (helper does less than half the effort) with eating, oral hygiene, toileting, lower body dressing, putting on and taking off footwear, and personal hygiene. During a review of Resident 1's Care plan (CP), initiated on 1/14/2026 and revised on 2/4/2026, the CP indicated to educate staff about type of abuse, including physical restraint, prevention measures, how and when to report it, resident safety and rights are respect and psychiatric consult.During a review of Resident 1's Progress Note, dated 1/15/2026 timed at 8:45 a.m., the Progress Note indicated that during the night shift on 1/14/2026 (time not indicated), Resident 1 was restless, yelling on and off and LVN 1 asked CNA 1 to check on Resident 1. The Progress Note indicated that CNA 1 came out from Resident 1's room and stated that Resident 1 was okay and always behaves like this but after approximately 10 minutes later, Resident 1 was again yelling in her language. The Progress Note indicated LVN 1 entered Resident 1's room, saw Resident 1's blanket on the floor, picked up the blanket, and was about to place the blanket on Resident 1, who was lying in her bed, when LVN 1 saw Resident 1's wrist tied in front of her (Resident 1) by what looked like to be a long scarf. The Progress Note indicated LVN 1 untied the scarf and quickly assessed Resident 1 with no visible injury noted. During a review of Resident 1's Interdisciplinary Care Conference (IDT- a meeting where a patient's health team such as doctors, nurses, therapists, and social workers-collaborates to review progress, share expertise, and (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	create a unified, personalized treatment plan) dated 1/16/2026 at 11 a.m., the IDT indicated following an alleged abuse report IDT recommendations MD was contacted and orders were received for Urinary Analysis (UA-test that examines a urine sample's color, chemical makeup, and microscopic content to detect infections, kidney disease, diabetes, and overall health issues), Culture and Sensitivity (C&S- identifies the specific germ [bacteria or fungus] causing an infection and determines which medication best kills it), Complete Blood Count (CBC- blood test that measures the types, numbers, and health of cells in your blood), Comprehensive Metabolic Panel (CMP- a routine blood test that checks 14 different substances to assess your overall health, organ function, and chemical balance) and Thyroid Stimulating Hormone (TSH- checks how well your thyroid gland is working) related to any infection. As an infection can be a contributing factor to restless.During a review of Resident 1's COC Evaluation dated 1/16/2026 at 11:54 a.m. the COC indicated restlessness as discussed during IDT. Resident 1 reported with having restless behavior at night that was discussed during IDT meeting. MD notified and ordered UA with C&S, CBC, CMP and TSH. During a review of Resident 1's Order Audit Report dated 1/16/2026 at 11:59 a.m. the Order Audit Report indicated:- CBC, CMP, TSH, one time only for one day.- UA, C&S one time only for one day.During a review of Resident 1's COC dated 1/17/2026 at 10:39 a.m. the COC indicated UTI. Abnormal UA result noted by RN supervisor. Reported to MD and received order for Macrobid orally 100 milligrams (mg- a unit of measurement) two times a day for urinary tract infection (UTI- an infection in the bladder/urinary tract) for one week. Resident 1 has no pain or discomfort and no fever noted. Family notified. During a review of Resident 1's Order Audit Report dated 1/17/2026 at 10:13 a.m. the Order Audit Report indicated Macrobid oral capsule 100 mg give 100 mg by mouth every 12 hours for UTI for one week. During an interview on 1/28/2026 at 11 a.m. with the DON and the RMN, the DON stated on 1/14/2026 LVN 1 stated she (LVN 1) took a picture showing Resident 1's tied with a silk scarf.During an interview on 1/28/2026 at 11:25 a.m. with CNA 1, CNA 1 stated worked on 1/13/2026 the 11 p.m. to 7 a.m. shift and was the CNA for Resident 1. CNA 1 stated Resident 1 was confused, incontinent, sometimes is quiet and sometimes is not, Resident 1 will try to get out of bed. CNA 1 stated she did not see Resident 1's wrist tied, not sure what happened CNA 1 stated did not tie Resident 1's hands. CNA 1 stated continued to work with Resident 1 until the end of her (CNA 1) shift, was not taken off Resident 1's care. During an interview on 1/28/2026 at 1:02 p.m. with the RMN, the RMN stated when she saw the picture of Resident 1 tied up, RMN stated Resident 1's hands were tied in front on top of each other like a cross, cannot say if the scarf was tight or not. RMN stated when a resident is tied up it can prevent the resident from getting up, the resident would not be able to use the call light. RMN stated Resident 1 is a fall risk, can result in the resident attempting to get up and hurt themselves because their hands are tied, would not be able to catch themselves if falling. The RMN stated can be a potential for Resident 1 not to be able to drink as well. The RMN stated a COC was conducted during IDT on 1/16/2026 and that is when we notified the MD regarding the restlessness and that is when we obtained and order for labs and Resident 1 and was later noted with a UTI. The RMN stated COC form is to note a change in condition in the residents and to conduct and assessment on the resident. The RMN stated there was no COC for 1/14/2026.During an interview on 1/28/2026 at 2:49 p.m. with LVN 1, LVN 1 stated worked on 1/13/2026 11 p.m. to 7 a.m. and on 1/13/2026 around 1:30 a.m. to 2 a.m. heard Resident 1 making sound like Resident 1 was chanting in a different language, LVN 1 stated she (LVN 1) does not speak that language was unable to understand what Resident 1 was saying. LVN 1 stated she asked CNA 1 who was Resident 1's CNA and speaks the same language as Resident 1 what Resident 1 was saying and CNA 1 responded with she (Resident 1) always does that. LVN 1 stated a few minutes later Resident 1 got louder and the chanting (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	increased in frequency then asked CNA 1 to check on Resident 1, CNA1 went into Resident 1's room and Resident 1 got worse, Resident 1 louder and the chanting was constant, CNA 1 then left Resident 1's room. LVN 1 stated around 2:50 a.m. went into Resident 1's room and saw Resident 1's blanket on the floor and thought Resident 1 might be cold. LVN 1 stated she bent down to get the blanket shook the blanket and noted Resident 1's hands were bound. LVN 1 stated Resident 1's hands were bound at the wrist with a scarf, in front of Resident 1 real firm, the resident had no way of getting out there was no wiggle room, Resident 1 would not be able to move hands. LVN 1 stated Resident 1 was tied with a figure eight (8) at least three times, Resident 1 was hog tied. LVN 1 stated prior to removing the scarf took a picture of Resident 1 to show her supervisors, then called the OMB as she untied Resident 1 around 3 a.m. LVN 1 stated when she initially came into Resident 1's room Resident 1 looked relieved and became wiggly she was moving around wanting LVN 1 to see Resident 1 was bound. LVN 1 stated after that looked for CNA1 and she was at the desk, CNA 1 was asleep was snoring.During an interview on 2/2/2026 at 11:35 a.m. with MD1, MD 1 stated was notified a few weeks ago, one of the staff found Resident 1 with a scarf like thing over her wrist tied. MD 1 stated was told the next morning after the incident occurred and tis when he was told about Resident 1's restlessness, it was reported there was no skin issues and MD 1 ordered labs to ensure nothing was going on. MD 1 stated ordered UA and blood test because Resident 1 was more confused than usual. MD 1 stated if Resident 1 is more confused than normal then that would be a new COC. During an interview on 2/2/2026 at 3:19 p.m. with the DON stated was informed by LVN 1 on 1/14/2026 at 7:30 a.m. she had something important to tell them, LVN 1 stated let me show you a picture of a resident who was bound on her wrist and that is when LVN1 showed us the picture. The DON stated the picture showed Resident 1 bound by her wrist side by side with a greenish scarf, to me (DON) could not tell how tight it was but it looked solid there was no way the Resident 1 could have pulled arms apart. The DON stated this is physical abuse, used as a physical restraint, Resident 1 could have encouraged the potential for an injury from a fall due to her lack of mobility as her wrist were tied. The DON stated alleged abuse is considered a COC. The DON stated COC is a communication is a form that communicates with all staff, would have been given to nurses then, communicate to MD, IDT and family. The DON stated if there is no COC for 1/14/2026 allegation of abuse documented then we cannot say the MD, or family were notified of the COC.During a concurrent interview and record review on 2/3/2026 at 9:52 a.m. of Resident 1's Health Status Note with the RMN, the RMN stated there is no COC for Resident 1 on 1/14/2026. The RMN stated the COC would have been specifically for abuse and include the restlessness the restlessness was addressed on the OCC dated 1/16/2026. The RMN stated COC identity the COC, then will initiate 72- hour monitoring. The RMN stated the RN supervisor should have started the COC on 1/14/2026. The RMN reviewed Resident 1's Health Status Note dated 1/16/2026 at 7:25 a.m. and the RMN stated that is when the 72-hour monitoring was started. The RMN stated 72-hour monitoring should have started on 1/14/2026. The RMN stated the 72 hour monitoring is to ensure residents are being checked for their psychosocial wellbeing and any new skin issues like bruising from the restraint and the resident's overall status. The RMN stated there was a delay in Resident 1's restlessness, RMN stated on 1/16/2026 when she spoke to MD1 asked if it was possible for Resident 1 to have a UTI. The RMN stated MD1 was notified but he had no orders at the time and 1/14/2026. The RMN stated basic nursing if not documented cannot say MD was notified, the RMN stated there is no documentation MD was notified on 1/14/2026. During a review of the facility's policy and procedure (P&P) titled, Change of Condition Notification, last reviewed on 7/28/2025, the P&P indicated to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. II. The facility (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal representative when the resident endures a significant change in their condition caused by, but not limited to:b. A significant change in the resident's physical, cognitive, behavioral or functional statusDocumentationA. A Licensed Nurse will document the following:i. Date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes.ii. The time the Attending Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received. iii. The time the family/responsible person was contactediv. Update the Care Plan to reflect the resident's current statusv. The incident and brief detail in the 24-hour report C. A Licensed Nurse will document each shift for at least seventy-two (72) hours.

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the right of one of three sampled residents (Resident 1) to be free from physical restraint (is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: is attached or adjacent to the resident's body; cannot be removed easily by the resident; and restricts the resident's freedom of movement or normal access to his/her body). On 1/14/2026 at 3 a.m., Licensed Vocational Nurse (LVN) 1 found the hands of Resident 1, who had severe cognitive impairment (is a profound, often irreversible loss of mental capacity involving a major inability to think, remember, learn, communicate, or make decisions, requiring daily assistance with basic tasks like eating, dressing, or safety) and was dependent on staff (helper does all of the effort) for care, were firmly tied together at the wrist with a scarf with no way of getting out, no wiggle room, and with no ability to move or release her hands while Resident 1 was in bed in her (Resident 1) room. The facility failed to: 1. Ensure that a licensed nurse completed an assessment prior to the application of a physical restraint restricting Resident 1's freedom of movement in accordance with the facility's policy and procedure (P&P) titled, Restraints, last reviewed on 7/28/2025, indicating, . a physical restraint shall be used only after the interdisciplinary team (IDT - a collaborative group of healthcare professionals who work together to create, implement, and evaluate a personalized, comprehensive care plan for residents) has performed an assessment, attempted to determine and alleviate precipitating factors, determined the need for restraint and identified the least restrictive device. 2. Ensure Certified Nursing Assistant (CNA) 1, who was assigned to Resident 1, was suspected of tying Resident 1's hands, and was caught sleeping during that time, was immediately removed from duty on 1/14/2026 at 3 a.m. CNA 1 remained on schedule and continued providing care to Resident 1 until clocking out at 7:16 a.m. on 1/14/2026. This failure allowed potential continued or further abuse. The facility failed to follow its P&P titled, Abuse Prevention and Prohibition Program, last reviewed on 7/28/2025, indicating, Facility staff members accused of committing abuse, neglect or mistreatment against a resident are suspended until the investigation is complete and the findings have been reviewed by the Administrator. 3. Follow the facility's P&P titled, Restraints, dated 11/1/2017, indicating, Residents shall be provided an environment that is restraint-free. The facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. The facility will ensure that restraints will not be imposed for purposes of discipline or convenience. 4. Follow the facility's P&P titled, Abuse Prevention and Prohibition Program, last reviewed on 7/28/2025, indicating, Each resident has the right to be free from abuse, neglect, mistreatment. The Facility has zero-tolerance for abuse. Staff must not permit anyone to engage in . physical abuse, neglect, mistreatment. The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff. As a result, on 1/14/2026, CNA 1 allegedly subjected Resident 1 to a physical restraint while under the care of the facility. On 1/14/2026 at 2 a.m., LVN 1 heard Resident 1 chanting which became louder, increased in frequency, and getting worse. On 1/14/2026 at around 2:50 a.m., LVN 1 entered Resident 1's room and found Resident 1's blanket on the floor and Resident 1 who was lying in her bed making wiggly (quick, irregular shaking or twisting motion from side to side or up and down) body movements to show LVN 1 her hands were bound with a scarf. Also, 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 [relating to the interrelation of social factors and individual thought and behavior] outcome the deficiency may have had (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on a reasonable person in the resident's position), due to Resident 1's severe impaired cognitive skills and medical condition, 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. On 2/3/2026 at 12 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility's non-compliance with one or more requirements of participations has caused, or is likely to cause, serious injury, harm, impairment, or death of a resident) in the presence of the Administrator (Adm), the Director of Nursing (DON), and the Risk Management Nurse (RMN) due to the facility's failure to protect Resident 1's right to be free from physical restraint beginning on 1/14/2026 at 3 a.m., when LVN 1 found the hands of Resident 1 firmly tied together at the wrist with a scarf with no way of getting out, no wiggle room, and with no ability to move or release her hands while under the care of the facility. On 2/4/2026 at 4:26 p.m., the RMN provided an acceptable IJ removal plan (a detailed plan to address the IJ findings) for the facility's failure to protect Resident 1's right to be free from physical restraint on 1/14/2026 at 3 a.m. On 2/4/2026 at 4:50 p.m., while onsite at the facility, the SSA verified and confirmed the facility's full implementation of the IJ Removal Plan through observations, interviews, and record reviews, and determined the IJ situation regarding the facility's failure to protect Resident 1's right to be free from physical restraint was no longer present. The SSA removed the IJ situation, while onsite, on 2/4/2026 at 4:50 p.m., in the presence of the DON and the RMN. The immediate jeopardy was removed on 2/4/2026, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not IJ (noncompliance causing minimal discomfort or potential to compromise resident functioning). The acceptable IJ Removal Plan included the following summarized actions: 1. On 1/14/2026 at about 7:20 a.m., LVN 1 reported to the facility's Human Resources (HR) and the DON the alleged abuse incident. Upon reporting to the DON, LVN 1 stated that Resident 1 was found with her (Resident 1) hands bound by a scarf, and she (LVN 1) immediately removed the scarf and notified the Ombudsman (OMB- an advocate for residents of nursing homes, board and care centers, and assisted living facilities). 2. On 1/14/2026 at 7:45 a.m. the facility suspended CNA 1 pending HR's investigation. 3. On 1/15/2026 at 7:45 a.m. LVN 1 was provided with written warning due to her failure to report the incident to the RN Supervisor on duty, who would have suspended CNA 1 immediately. 4. On 1/16/2026, the facility terminated CNA 1. 5. On 1/28/2026 at 1:58 p.m., the Director of Staff Development (DSD) reported CNA 1 to the CNA Licensing Board. 6. On 2/3/2026, Registered Nurse (RN) Supervisors 1, 2, and 3 conducted rounds on all units to visually observe all residents in-house for any signs of physical restraints, inappropriate use of devices that could function as restraints, or any signs of abuse or neglect. No other residents were identified. 7. On 2/3/2026 at 9 :30 p.m., RN Supervisors 4, 5, 6, and 7 conducted another facility-wide sweep of all residents to screen for restraints. No other residents were identified. 8. On 2/3/2026 at 2 p.m., the facility's HR and Adm suspended LVN 1 due to failure to follow facility's policy (did not indicate which policy). 9. On 2/3/2026, the Assistant DSD initiated an in-serviced facility staff regarding restraints and the Assistant DSD and DSD will continue to provide in-services until completion by 2/6/2026. During orientation, facility will in-service newly hired staff on abuse and physical restraints. The in-service will include: a. Review of facility's Abuse Prevention and Prohibition Program policy, with emphasis on Residents being free from physical restraints, regulatory requirements and facility policy regarding physical restraints, including the definition of physical restraint, prohibition of restraints for discipline or convenience, and requirement for physician orders and (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	assessments. b. Resident rights including the right to be free from restraints and abuse. c. Immediate reporting requirements. d. Facility's zero-tolerance policy for abuse and requirement to report suspected abuse immediately. e. Documentation requirements. 10. On 2/4/2026 at 12 p.m., the DON created a root cause analysis (a structured, team-based, and non-punitive process used to investigate and to uncover underlying system, process, or human factor [NAME] rather than assigning individual blame). 11. On 2/4/2026, the Adm and DON instructed staff that there will be immediate removal of staff from duty when abuse/neglect is suspected. 12. Effective 2/4/2026, shift to shift report (handover process where the nurse ending his/her shift transfers responsibility, accountability, and essential resident information to the incoming staff member) will include report of any suspected abuse and immediate suspension of staff involved. 13. Department Managers, Managers of the Day, and RN Supervisor on duty will conduct daily rounds inclusive of every shift, weekends and holidays to validate no restraints observed weekly for four weeks, then monthly for two months, to ensure residents feel safe and are free from restraints.Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 8/16/2025 with diagnosis including dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), muscle weakness (general), and abnormalities of gait (manner of walking) and mobility (ability to move). During a review of Resident 1's Physician History and Physical (H&P- a process used by doctors to understand residents' health which combines medical history and a physical examination), dated 9/5/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Fall Risk Assessment (a process used by healthcare providers to determine a resident's likelihood of falling), dated 12/8/2025, the Fall Risk Assessment indicated Resident 1's fall risk score was 21 meaning Resident 1 was a high risk for fall. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/8/2025, the MDS indicated Resident 1 rarely understood and was rarely understood. The MDS indicated Resident 1 was dependent on staff for showering, required substantial assistance (helper does more than half the effort) with upper body dressing, and required partial assistance (helper does less than half the effort) with eating, oral hygiene, toileting, lower body dressing, putting on and taking off footwear, and personal hygiene. During a review of CNA 1's Timecard, dated 1/13/2026, the Timecard indicated CNA 1 clocked into work on 1/13/2026 10:46 p.m. and clocked out on 1/14/2026 at 7:16 a.m. During a review of Resident 1's Progress Note, dated 1/15/2026 timed at 8:45 a.m., the Progress Note indicated that during the night shift on 1/14/2026 (time not indicated), Resident 1 was restless, yelling on and off and LVN 1 asked CNA 1 to check on Resident 1. The Progress Note indicated that CNA 1 came out from Resident 1's room and stated that Resident 1 was okay and always behaves like this but after approximately 10 minutes later, Resident 1 was again yelling in her language. The Progress Note indicated LVN 1 entered Resident 1's room, saw Resident 1's blanket on the floor, picked up the blanket, and was about to place the blanket on Resident 1, who was lying in her bed, when LVN 1 saw Resident 1's wrist tied in front of her (Resident 1) by what looked like to be a long scarf. The Progress Note indicated LVN 1 untied the scarf and quickly assessed Resident 1 with no visible injury noted. During a concurrent interview and record review on 1/28/2026 at 9 a.m. with the Adm, CNA 1's Timecard on 1/13/2026 was reviewed. The Adm stated CNA 1 clocked in on 1/13/2026 at 10:46 p.m. and clocked out on 1/14/2026 at 7:16 a.m. During an interview on 1/28/2026 at 11:25 a.m. with CNA 1, CNA 1 stated she worked on 1/13/2026 during the 11 p.m. to 7 a.m. shift (work schedule) and was the CNA for Resident 1. CNA 1 stated she continued to work with Resident 1 until the end of her (CNA 1) shift. CNA 1 stated she was not taken off Resident 1's care. During an interview on (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1/28/2026 at 1:02 p.m. with the RMN, the RMN stated she saw the picture of Resident 1's hands tied up in the front (of Resident 1) on top of each other like a cross, but she cannot say if the scarf was tight or not. The RMN stated that when a resident is tied up it can prevent the resident from getting up and, also, the resident would not be able to use the call light. The RMN stated Resident 1 was a fall risk and this can result in Resident 1 attempting to get up and hurt herself because her hands were tied and would not be able to catch herself if falling. The RMN stated this can be a potential for Resident 1 not to be able to drink water, as well. The RMN stated CNA 1 completed her shift and continued to work with Resident 1 on 1/14/2026. The RMN stated LVN 1 should have removed CNA 1 immediately from the assignment and should have left the premises of the facility. During an interview on 1/28/2026 at 2:49 p.m. with LVN 1, LVN 1 stated she worked on 1/13/2026 during the 11 p.m. to 7 a.m. shift. LVN 1 stated on 1/13/2026 at around 1:30 a.m. to 2 a.m. she heard Resident 1 making sounds like Resident 1 was chanting in a different language. LVN 1 stated she (LVN 1) does not speak that language and was unable to understand what Resident 1 was saying. LVN 1 stated she asked CNA 1, who was Resident 1's assigned CNA and speaks the same language as Resident 1, what Resident 1 was saying and CNA 1 responded that Resident 1 always did that. LVN 1 stated that a few minutes later (did not indicate exact time) Resident 1's chanting got louder and increased in frequency. LVN 1 stated she asked CNA 1 to check on Resident 1, so CNA 1 went into Resident 1's room, talked with Resident 1, and left Resident 1's room. LVN 1 stated Resident 1's chanting got worse and getting louder and around 2:50 a.m. (on 1/14/2026) LVN 1 went into Resident 1's room and saw Resident 1's blanket on the floor and thought Resident 1, who was lying in her bed, might be cold. LVN 1 stated she bent down to get the blanket, shook the blanket, and noted Resident 1's hands were bound. LVN 1 stated Resident 1's hands were firmly bound at the wrist with a scarf, in front of Resident 1 with no way of getting out and no wiggle room. LVN 1 stated Resident 1's hands were hog tied tied at the wrist with a figure eight at least three times. LVN 1 stated that prior to removing the scarf she took a picture of Resident 1's tied hands to show to her supervisors and untied Resident 1 around 3 a.m. LVN 1 stated that when she initially came into Resident 1's room Resident 1 looked relieved and became wiggly as she was moving around wanting LVN 1 to see she (Resident 1) was bound. LVN 1 stated that after that she looked for CNA 1 and she saw CNA 1 at the desk in the Nursing Station sleeping and snoring (woke up at unknown time to continue her shift). LVN 1 stated CNA 1 completed her (CNA 1) shift taking care of Resident 1. During an interview on 1/28/2026 at 3:32 p.m. with the RMN, the RMN stated this is abuse, because Resident 1 was unable to move due to being tied down. The RMN stated there was no way to determine how long Resident 1 was tied down. The RMN stated having CNA 1 still work after allegation of abuse placed Resident 1 at further risk and other residents at risk of abuse. During an interview on 2/2/2026 at 3:19 p.m. with the DON, the DON stated LVN 1 showed a picture of Resident 1 whose hands were bound by her wrists, side by side, with a greenish scarf. The DON stated she could not tell how tight it was, but it looked solid that there was no way Resident 1 could have pulled her arms apart. The DON stated the scarf would inhibit Resident 1 from grabbing the handrails and thinks that was why it was done to prevent Resident 1 from pulling herself up and getting out of the bed. The DON stated Resident 1 would not be able to use the call light and the way her wrists were bound she would not be able to drink water or even scratch her face. The DON stated that because Resident 1's hands were tied Resident 1 was at a higher risk for falling due to not being able to balance. The DON stated she thought CNA 1 bound Resident 1's hands to prevent Resident 1 from getting up out of bed. The DON stated there was no assessment specifically for the use of the scarf as a restraint. The DON stated the scarf was used as a restraint. The DON stated the scarf was used as convenience (continued on next page)

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	555579	A. Building B. Wing	02/04/2026

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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for CNA 1 because CNA 1 knew Resident 1 would not be able to get out of bed. The DON stated this was physical abuse and use of physical restraint because Resident 1 could have the potential for an injury from a fall due to her lack of mobility as her wrists were tied. The DON stated because she (Resident 1) was bound, Resident 1 was restricted, and this would impact Resident 1's sleep. The DON stated that psychosocially this would affect Resident 1's mental status because Resident 1 would be confused why she was unable to move. The DON stated Resident 1's increased chanting was indicative of Resident 1 being agitated because she was bound. The DON stated the scarf was used as a restraint on Resident 1. The DON stated it was not a proper way of using scarf as a restraint. The DON stated there is no policy where the facility can use a scarf as a restraint. The DON stated when a restraint is used, the facility must conduct a total assessment to ensure the resident is able to remove the restraint, must be documented and signed off, and there must be a consent for the use of the restraint. The DON stated there was no assessment and/or consent for the use of a scarf as a restraint for Resident 1. During an interview on 2/2/2026 at 4:44 p.m. with the Adm, the Adm stated he is the facility's abuse coordinator. The Adm stated Resident 1 being tied with a scarf is a form of restraint and it falls under abuse. The Adm stated this would be physical abuse. The Adm stated he believed CNA 1 was the one that tied Resident 1, and it was for the convenience of CNA 1 because Resident 1 was restless during that time. The Adm stated CNA 1 should have been removed immediately from the work schedule once LVN 1 found Resident 1 was bound because there was a potential for CNA 1 to do it to other residents, and can get in the way of the investigation, as well. During a review of the facility's P&P titled, Abuse Prevention and Prohibition Program, last reviewed on 7/28/2025, the P&P indicated, Each resident has the right to be free from abuse, neglect, mistreatment. The facility has zero-tolerance for abuse , neglect, mistreatment. Staff must not permit anyone to engage in . physical abuse, neglect, mistreatment. The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff. A. The facility protects residents during investigation of abuse, neglect or mistreatment. B. Facility staff members accused of committing abuse, neglect or mistreatment against a resident are suspended until the investigation is complete and the findings have been reviewed by the Administrator. During a review of the facility's P&P titled, Restraints, last reviewed on 7/28/2025, the P&P indicated, Residents shall be provided an environment that is restraint-free, unless a restraint is necessary to treat a medical symptom in which case the least restrictive measure shall be used. The facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. The facility will ensure that restraints will not be imposed for purposes of discipline or convenience. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention and a restraint is required to: A. Treat the medical symptom (something a person feels or experiences that may indicate they have a disease or condition); B. Protect the resident's safety; and C. Help the resident attain the highest level of his/her physical or psychological well-being. Except in emergency situation, a physical restraint shall be used only after the interdisciplinary team (IDT) has performed an assessment, attempted to determine and alleviate precipitating factors, determined the need for restraint and identified the least restrictive device. Assessment - An assessment will be completed by a Licensed Nurse prior to the application of any device that restricts movement or access to one's body.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to implement its Abuse Prevention and Prohibition Program Policy and Procedures (P&P) by failing to report the alleged abuse to the State Survey Agency (SSA), and local law enforcement, in accordance with the facility's policy no later than two (2) hours after the allegation occurred for one of three sampled residents (Resident 1) when on 1/14/2026 at 2:50 a.m. Licensed Vocation Nurse (LVN) 1, observed Resident 1 with her wrists bound.This deficient practice had the potential to result in unidentified abuse and placed Resident 1 at risk for further abuse.Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 8/16/2025 with diagnosis including dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), muscle weakness (general), and abnormalities of gait (manner of walking) and mobility (ability to move).During a review of Resident 1's Physician History and Physical (H&P- a process used by doctors to understand residents' health which combines medical history and a physical examination), dated 9/5/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Fall Risk Assessment (a process used by healthcare providers to determine a resident's likelihood of falling), dated 12/8/2025, the Fall Risk Assessment indicated Resident 1's fall risk score was 21 meaning Resident 1 was a high risk for fall. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/8/2025, the MDS indicated Resident 1 rarely understood and was rarely understood. The MDS indicated Resident 1 was dependent on staff for showering, required substantial assistance (helper does more than half the effort) with upper body dressing, and required partial assistance (helper does less than half the effort) with eating, oral hygiene, toileting, lower body dressing, putting on and taking off footwear, and personal hygiene.During a review of CNA 1's Timecard, dated 1/13/2026, the Timecard indicated CNA 1 clocked into work on 1/13/2026 10:46 p.m. and clocked out on 1/14/2026 at 7:16 a.m. During a review of Resident 1's Progress Note, dated 1/15/2026 timed at 8:45 a.m., the Progress Note indicated that during the night shift on 1/14/2026 (time not indicated), Resident 1 was restless, yelling on and off and LVN 1 asked CNA 1 to check on Resident 1. The Progress Note indicated that CNA 1 came out from Resident 1's room and stated that Resident 1 was okay and always behaves like this but after approximately 10 minutes later, Resident 1 was again yelling in her language. The Progress Note indicated LVN 1 entered Resident 1's room, saw Resident 1's blanket on the floor, picked up the blanket, and was about to place the blanket on Resident 1, who was lying in her bed, when LVN 1 saw Resident 1's wrist tied in front of her (Resident 1) by what looked like to be a long scarf. The Progress Note indicated LVN 1 untied the scarf and quickly assessed Resident 1 with no visible injury noted. During an interview on 1/28/2026 at 1:02 p.m. with the RMN, the RMN stated she saw the picture of Resident 1's hands tied up in the front (of Resident 1) on top of each other like a cross, but she cannot say if the scarf was tight or not. The RMN stated that when a resident is tied up it can prevent the resident from getting up and, also, the resident would not be able to use the call light. The RMN stated Resident 1 was a fall risk and this can result in Resident 1 attempting to get up and hurt herself because her hands were tied and would not be able to catch herself if falling. The RMN stated this can be a potential for Resident 1 not to be able to drink water, as well. The RMN stated LVN 1 should have reported immediately to the Adm because LVN 1 notified the DON and RMN at around 7:15 a.m. to 7:20 a.m. (on 1/14/2026) causing a delay of about three hours in reporting the abuse. The RMN stated CNA 1 completed her shift and continued to work with Resident 1 on 1/14/2026. The RMN stated LVN 1 should have removed CNA 1 immediately from the assignment and (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have left the premises of the facility.During an interview on 1/28/2026 at 2:49 p.m. with LVN 1, LVN 1 stated she worked on 1/13/2026 during the 11 p.m. to 7 a.m. shift. LVN 1 stated on 1/13/2026 at around 1:30 a.m. to 2 a.m. she heard Resident 1 making sounds like Resident 1 was chanting in a different language. LVN 1 stated she (LVN 1) does not speak that language and was unable to understand what Resident 1 was saying. LVN 1 stated she asked CNA 1, who was Resident 1's assigned CNA and speaks the same language as Resident 1, what Resident 1 was saying and CNA 1 responded that Resident 1 always did that. LVN 1 stated that a few minutes later (did not indicate exact time) Resident 1's chanting got louder and increased in frequency. LVN 1 stated she asked CNA 1 to check on Resident 1, so CNA 1 went into Resident 1's room, talked with Resident 1, and left Resident 1's room. LVN 1 stated Resident 1's chanting got worse and getting louder and around 2:50 a.m. (on 1/14/2026) LVN 1 went into Resident 1's room and saw Resident 1's blanket on the floor and thought Resident 1, who was lying in her bed, might be cold. LVN 1 stated she bent down to get the blanket, shook the blanket, and noted Resident 1's hands were bound. LVN 1 stated Resident 1's hands were firmly bound at the wrist with a scarf, in front of Resident 1 with no way of getting out and no wiggle room. LVN 1 stated Resident 1's hands were hog tied tied at the wrist with a figure eight at least three times. LVN 1 stated that prior to removing the scarf she took a picture of Resident 1's tied hands to show to her supervisors and untied Resident 1 around 3 a.m. LVN 1 stated that when she initially came into Resident 1's room Resident 1 looked relieved and became wiggly as she was moving around wanting LVN 1 to see she (Resident 1) was bound. LVN 1 stated that after that she looked for CNA 1 and she saw CNA 1 at the desk in the Nursing Station sleeping and snoring (woke up at unknown time to continue her shift). LVN 1 stated CNA 1 completed her (CNA 1) shift taking care of Resident 1.During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program, last reviewed on 7/28/2025, the P&P indicated each resident has the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. The facility has zero-tolerance for abuse, neglect, mistreatment, an/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. ProtectionA. The facility protects residents during investigation of abuse, neglect or mistreatment.B. Facility staff members accused of committing abuse, neglect or mistreatment against a resident are suspended until the investigation is complete and the findings have been reviewed by the Administrator. Reporting/Response B. The Administrator is the Abuse Coordinatorii. Facility Staff will report known or suspected instance of abuse to the Administer, or his/her designee.C. All mandated reporters will report reasonable suspicion of a crime against a resident when it is objectively reasonable for a person to entertain a suspicion of conduct that appears to be financial abuse, physical abuse, neglect, abandonment, isolation, abduction, or other treatment resulting in physical harm or pain or mental suffering, deprivation of goods or services that are necessary to avoid physical harm or mental suffering.i. Immediately, by telephone, but no later than 2 hours after forming the suspicion if the alleged violation involves abuse or results in serious bodily injury to the SSA, adult protective services, law enforcement, and the Ombudsmen.During a review of the facility's P&P titled, Restraints, last reviewed on 7/28/2025, the P&P indicated residents shall be provided an environment that is restraint-free, unless a restraint is necessary to treat a medical symptom in which case the least restrictive measure shall be used.Physical Restraint is defined as any manual method or physical or mechanical devise, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. ii. The facility honors the resident's right to be free from any restraints that are (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	imposed for reasons other than that of treatment of the resident's medical symptoms. The Facility will ensure that restraints will not be imposed for purpose of discipline or convivence.VII. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention and a restraint is required to:A. Treat the medical symptom;B. Protect the resident's safety; andC. Help the resident attain the highest level of his/her physical or psychological well-beingX. Except in emergency situation, a physical restraint shall be used only after the interdisciplinary tea, (IDT) has performed an assessment, attempted to determine and alleviate precipitating factors, determined the need for restraint and identified the least restrictive device.Assessment- An assessment will be completed by a Licensed Nurse prior to the application of any device that restricts movement or access to one's body. The assessment will be repeated quarterly thereafter. If a resident is admitted with a restraint, the assessment will be completed upon admission.VI. Physician order- There must be a physician's order for the use of the restraint which include:A. Medical symptoms for the use:B. Frequency of use;C. Type of restraint;D. Release protocols; andE. Plan of reduction, when applicableVII. Informed consentA. Before any type of restraint is used, the Licensed Nurse will verify that informed consent has been obtained form the resident/responsible party and that the resident/responsible party was educated regarding the risks and benefits of restraint use.X. Care Planning-Care plans for resident with restraints will reflect:A. the type of restraint to be used;B. the medical symptoms requiring the use of restraints;C. The treatment team's goals in using the restraint;D. Interventions that address the immediate medical symptom(s) and the underlying problem that may be causing the symptom(s);E. Systemic and gradual approaches for minimizing or eliminating the concerning behavior and restraint use, and F. Frequency observation and release every 2 hours for toileting and/or repositioning and checking the condition of skin and impaired circulation if indicated.G. The use of postural support and the method of application will be specified in the resident's Care Plan.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to take precautionary measures to provide protection to one of three sampled Residents (Resident 1) when, on 1/14/2026 at 3 a.m. Certified Nursing Assistant (CNA) 1 who was assigned to Resident 1 tied Resident 1's hands together at the wrist with a scarf while Resident 1 was in bed in her (Resident 1) room. CNA 1 was able to continue to work with Resident 1 and all other residents in the facility until she clocked out on 1/14/2026 at 7:16 a.m.This deficient practice had the potential to place Resident 1 and other residents at risk for further abuse.Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 8/16/2025 with diagnosis including dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), muscle weakness (general), and abnormalities of gait (manner of walking) and mobility (ability to move). During a review of Resident 1's Physician History and Physical (H&P- a process used by doctors to understand residents' health which combines medical history and a physical examination), dated 9/5/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Fall Risk Assessment (a process used by healthcare providers to determine a resident's likelihood of falling), dated 12/8/2025, the Fall Risk Assessment indicated Resident 1's fall risk score was 21 meaning Resident 1 was a high risk for fall. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/8/2025, the MDS indicated Resident 1 rarely understood and was rarely understood. The MDS indicated Resident 1 was dependent on staff for showering, required substantial assistance (helper does more than half the effort) with upper body dressing, and required partial assistance (helper does less than half the effort) with eating, oral hygiene, toileting, lower body dressing, putting on and taking off footwear, and personal hygiene. During a review of CNA 1's Timecard, dated 1/13/2026, the Timecard indicated CNA 1 clocked into work on 1/13/2026 10:46 p.m. and clocked out on 1/14/2026 at 7:16 a.m. During a review of Resident 1's Progress Note, dated 1/15/2026 timed at 8:45 a.m., the Progress Note indicated that during the night shift on 1/14/2026 (time not indicated), Resident 1 was restless, yelling on and off and LVN 1 asked CNA 1 to check on Resident 1. The Progress Note indicated that CNA 1 came out from Resident 1's room and stated that Resident 1 was okay and always behaves like this but after approximately 10 minutes later, Resident 1 was again yelling in her language. The Progress Note indicated LVN 1 entered Resident 1's room, saw Resident 1's blanket on the floor, picked up the blanket, and was about to place the blanket on Resident 1 when LVN 1 saw Resident 1's wrist tied in front of her (Resident 1) by what looked like to be a long scarf. The Progress Note indicated LVN 1 untied the scarf and quickly assessed Resident 1 with no visible injury noted. During a concurrent interview and record review on 1/28/2026 at 9 a.m. with the Adm, CNA 1's Timecard on 1/13/2026 was reviewed. The Adm stated CNA 1 clocked in on 1/13/2026 at 10:46 p.m. and clocked out on 1/14/2026 at 7:16 a.m. During an interview on 1/28/2026 at 11:25 a.m. with CNA 1, CNA 1 stated she worked on 1/13/2026 during the 11 p.m. to 7 a.m. shift (work schedule) and was the CNA for Resident 1. CNA 1 stated she continued to work with Resident 1 until the end of her (CNA 1) shift. CNA 1 stated she was not taken off Resident 1's care. During an interview on 1/28/2026 at 1:02 p.m. with the RMN, the RMN stated she saw the picture of Resident 1's hands tied up in the front (of Resident 1) on top of each other like a cross, but she cannot say if the scarf was tight or not. The RMN stated that when a resident is tied up it can prevent the resident from getting up and, also, the resident would not be able to use the call light. The RMN stated Resident 1 was a fall risk and this can result in Resident 1 attempting to get up and hurt herself because her hands were tied and would not be able to catch herself if falling. The RMN stated this can be a (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	potential for Resident 1 not to be able to drink water, as well. The RMN stated LVN 1 should have reported immediately to the Adm because LVN 1 notified the DON and RMN at around 7:15 a.m. to 7:20 a.m. (on 1/14/2026) causing a delay of about three hours in reporting the abuse. The RMN stated CNA 1 completed her shift and continued to work with Resident 1 on 1/14/2026. The RMN stated LVN 1 should have removed CNA 1 immediately from the assignment and should have left the premises of the facility. During an interview on 1/28/2026 at 2:49 p.m. with LVN 1, LVN 1 stated she worked on 1/13/2026 during the 11 p.m. to 7 a.m. shift. LVN 1 stated on 1/13/2026 at around 1:30 a.m. to 2 a.m. she heard Resident 1 making sounds like Resident 1 was chanting in a different language. LVN 1 stated she (LVN 1) does not speak that language and was unable to understand what Resident 1 was saying. LVN 1 stated she asked CNA 1, who was Resident 1's assigned CNA and speaks the same language as Resident 1, what Resident 1 was saying and CNA 1 responded that Resident 1 always did that. LVN 1 stated that a few minutes later (did not indicate exact time) Resident 1's chanting got louder and increased in frequency. LVN 1 stated she asked CNA 1 to check on Resident 1, so CNA 1 went into Resident 1's room, talked with Resident 1, and left Resident 1's room. LVN 1 stated Resident 1's chanting got worse and getting louder and around 2:50 a.m. (on 1/14/2026) LVN 1 went into Resident 1's room and saw Resident 1's blanket on the floor and thought Resident 1 might be cold. LVN 1 stated she bent down to get the blanket, shook the blanket, and noted Resident 1's hands were bound. LVN 1 stated Resident 1's hands were firmly bound at the wrist with a scarf, in front of Resident 1 with no way of getting out and no wiggle room. LVN 1 stated Resident 1's hands were hog tied tied at the wrist with a figure eight at least three times. LVN 1 stated that prior to removing the scarf she took a picture of Resident 1's tied hands to show to her supervisors and untied Resident 1 around 3 a.m. LVN 1 stated that when she initially came into Resident 1's room Resident 1 looked relieved and became wiggly as she was moving around wanting LVN 1 to see she (Resident 1) was bound. LVN 1 stated that after that she looked for CNA 1 and she saw CNA 1 at the desk in the Nursing Station sleeping and snoring. LVN 1 stated CNA 1 completed her (CNA 1) shift taking care of Resident 1. During an interview on 1/28/2026 at 3:32 p.m. with the RMN, the RMN stated this is abuse, because Resident 1 was unable to move due to being tied down. The RMN stated there was no way to determine how long Resident 1 was tied down. The RMN stated having CNA 1 still work after allegation of abuse placed Resident 1 at further risk and other residents at risk of abuse. During an interview on 2/2/2026 at 4:44 p.m. with the Adm, the Adm stated he is the facility's abuse coordinator. The Adm stated Resident 1 being tied with a scarf is a form of restraint and it falls under abuse. The Adm stated this would be physical abuse. The Adm stated he believed CNA 1 was the one that tied Resident 1, and it was for the convenience of CNA 1 because Resident 1 was restless during that time. The Adm stated CNA 1 should have been removed immediately from the work schedule once LVN 1 found Resident 1 was bound because there was a potential for CNA 1 to do it to other residents, and can get in the way of the investigation, as well. During a review of the facility's P&P titled, Abuse Prevention and Prohibition Program, last reviewed on 7/28/2025, the P&P indicated, Each resident has the right to be free from abuse, neglect, mistreatment. The facility has zero-tolerance for abuse, neglect, mistreatment. Staff must not permit anyone to engage in . physical abuse, neglect, mistreatment. The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff. A. The facility protects residents during investigation of abuse, neglect or mistreatment. B. Facility staff members accused of committing abuse, neglect or mistreatment against a resident are suspended until the investigation is complete and the findings have been reviewed by the Administrator.

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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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan (a document designed to facilitate communication among members of the care team that summarizes a resident's health conditions, specific care needs, and current treatments) for one of three sample residents (Resident 1) to address the use of restraints when on 1/14/2026 at 3 a.m. Certified Nursing Assistant (CNA) 1 who was assigned to Resident 1 tied Resident 1's hands together at the wrist with a scarf while Resident 1 was in bed in her (Resident 1) room.This deficient practice had the potential to negatively affect the care and services provided to Resident 1. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 8/16/2025 with diagnosis including dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), muscle weakness (general), and abnormalities of gait (manner of walking) and mobility (ability to move). During a review of Resident 1's Physician History and Physical (H&P- a process used by doctors to understand residents' health which combines medical history and a physical examination), dated 9/5/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Fall Risk Assessment (a process used by healthcare providers to determine a resident's likelihood of falling), dated 12/8/2025, the Fall Risk Assessment indicated Resident 1's fall risk score was 21 meaning Resident 1 was a high risk for fall. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/8/2025, the MDS indicated Resident 1 rarely understood and was rarely understood. The MDS indicated Resident 1 was dependent on staff for showering, required substantial assistance (helper does more than half the effort) with upper body dressing, and required partial assistance (helper does less than half the effort) with eating, oral hygiene, toileting, lower body dressing, putting on and taking off footwear, and personal hygiene.During a review of Resident 1's Care plan (CP), initiated on 1/14/2026 and revised on 2/4/2026, the CP indicated educate staff about type of abuse, including physical restraint, prevention measures, how and when to report it, resident safety and rights are respect and psychiatrist consult.During a review of Resident 1's Progress Note, dated 1/15/2026 timed at 8:45 a.m., the Progress Note indicated that during the night shift on 1/14/2026 (time not indicated), Resident 1 was restless, yelling on and off and LVN 1 asked CNA 1 to check on Resident 1. The Progress Note indicated that CNA 1 came out from Resident 1's room and stated that Resident 1 was okay and always behaves like this but after approximately 10 minutes later, Resident 1 was again yelling in her language. The Progress Note indicated LVN 1 entered Resident 1's room, saw Resident 1's blanket on the floor, picked up the blanket, and was about to place the blanket on Resident 1 when LVN 1 saw Resident 1's wrist tied in front of her (Resident 1) by what looked like to be a long scarf. The Progress Note indicated LVN 1 untied the scarf and quickly assessed Resident 1 with no visible injury noted. During a concurrent interview and record review on 2/4/2026 at 4:22 p.m. of Resident 1's Care plan for abuse with the RMN, the RMN reviewed Care plan and stated it was updated on 2/4/2026 but the way it is printed does not show the updated date. The RMN stated there was no previous care plan for the use of restraints for Resident 1 as Resident 1 was not using restraints. The RMN stated the use of the scarf was used as a restraint for Resident 1, should have had a care plan.During a review of the facility's policy and procedure (P&P) titled, Change of Condition Notification, last reviewed on 7/28/2025, the P&P indicated to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. II. The facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal (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	02/04/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative when the resident endures a significant change in their condition caused by, but not limited to:b. A significant change in the resident's physical, cognitive, behavioral or functional statusDocumentationA. A Licensed Nurse will document the following:i. Date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes.ii. The time the Attending Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received. iii. The time the family/responsible person was contactediv. Update the Care Plan to reflect the resident's current statusv. The incident and brief detail in the 24-hour report C. A Licensed Nurse will document each shift for at least seventy-two (72) hours.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) receive treatment and care in accordance with professional standards of practice when on 1/14/2026 at 3 a.m. Certified Nursing Assistant (CNA) 1 who was assigned to Resident 1 tied Resident 1's hands together at the wrist with a scarf while Resident 1 was in bed in her (Resident 1) room, the facility failed to:1. Failed to create a Change of Condition (COC) Evaluation for the alleged physical abuse2. Failed to start 72-hour monitoring (a watch period where staff closely observe a resident for three days to make sure the new health problem does not get worse) after Resident 1 had a COC.This deficient practice had the potential to negatively affect Resident 1's plan of care and delivery of necessary care and services.Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 8/16/2025 with diagnosis including dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), muscle weakness (general), and abnormalities of gait (manner of walking) and mobility (ability to move).During a review of Resident 1's Physician History and Physical (H&P- a process used by doctors to understand residents' health which combines medical history and a physical examination), dated 9/5/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Fall Risk Assessment (a process used by healthcare providers to determine a resident's likelihood of falling), dated 12/8/2025, the Fall Risk Assessment indicated Resident 1's fall risk score was 21 meaning Resident 1 was a high risk for fall. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/8/2025, the MDS indicated Resident 1 rarely understood and was rarely understood. The MDS indicated Resident 1 was dependent on staff for showering, required substantial assistance (helper does more than half the effort) with upper body dressing, and required partial assistance (helper does less than half the effort) with eating, oral hygiene, toileting, lower body dressing, putting on and taking off footwear, and personal hygiene.During a review of Resident 1's Care plan (CP), initiated on 1/14/2026 and revised on 2/4/2026, the CP indicated educate staff about type of abuse, including physical restraint, prevention measures, how and when to report it, resident safety and rights are respect and psychiatric consult.During a review of Resident 1's Progress Note, dated 1/15/2026 timed at 8:45 a.m., the Progress Note indicated that during the night shift on 1/14/2026 (time not indicated), Resident 1 was restless, yelling on and off and LVN 1 asked CNA 1 to check on Resident 1. The Progress Note indicated that CNA 1 came out from Resident 1's room and stated that Resident 1 was okay and always behaves like this but after approximately 10 minutes later, Resident 1 was again yelling in her language. The Progress Note indicated LVN 1 entered Resident 1's room, saw Resident 1's blanket on the floor, picked up the blanket, and was about to place the blanket on Resident 1 when LVN 1 saw Resident 1's wrist tied in front of her (Resident 1) by what looked like to be a long scarf. The Progress Note indicated LVN 1 untied the scarf and quickly assessed Resident 1 with no visible injury noted. During a review of Resident 1's Health Status Note created on 1/16/2026 at 7:25 a.m. with an effective date of 1/15/2026 at 2:50 p.m., the Health Status Note indicated Resident 1 on monitoring status post abuse incident. During a review of Resident 1's Interdisciplinary Care Conference (IDT- a meeting where a patient's health team such as doctors, nurses, therapists, and social workers-collaborates to review progress, share expertise, and create a unified, personalized treatment plan) dated 1/16/2026 at 11 a.m., the IDT indicated following an alleged abuse report IDT recommendations MD was contacted and orders were received for Urinary Analysis (UA-test that examines a urine sample's color, chemical makeup, and microscopic content to detect infections, kidney disease, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diabetes, and overall health issues), Culture and Sensitivity (C&S- identifies the specific germ [bacteria or fungus] causing an infection and determines which medication best kills it), Complete Blood Count (CBC- blood test that measures the types, numbers, and health of cells in your blood), Comprehensive Metabolic Panel (CMP- a routine blood test that checks 14 different substances to assess your overall health, organ function, and chemical balance) and Thyroid Stimulating Hormone (TSH- checks how well your thyroid gland is working) related to any infection. As an infection can be a contributing factor to restless.During a review of Resident 1's COC Evaluation dated 1/16/2026 at 11:54 a.m. the COC indicated restlessness as discussed during IDT. Resident 1 reported with having restless behavior at night that was discussed during IDT meeting. MD notified and ordered UA with C&S, CBC, CMP and TSH. During a review of Resident 1's Order Audit Report dated 1/16/2026 at 11:59 a.m. the Order Audit Report indicated:- CBC, CMP, TSH, one time only for one day.- UA, C&S one time only for one day.During a review of Resident 1's COC dated 1/17/2026 at 10:39 a.m. the COC indicated UTI. Abnormal UA result noted by RN supervisor. Reported to MD and received order for Macrobid orally 100 milligrams (mg- a unit of measurement) two times a day for urinary tract infection (UTI- an infection in the bladder/urinary tract) for one week. Resident 1 has no pain or discomfort and no fever noted. Family notified. During a review of Resident 1's Order Audit Report dated 1/17/2026 at 10:13 a.m. the Order Audit Report indicated Macrobid oral capsule 100 mg give 100 mg by mouth every 12 hours for UTI for one week. During an interview on 1/28/2026 at 1:02 p.m. with the RMN, the RMN stated when she saw the picture of Resident 1 tied up, RMN stated Resident 1's hands were tied in front on top of each other like a cross, cannot say if the scarf was tight or not. RMN stated when a resident is tied up it can prevent the resident from getting up, the resident would not be able to use the call light. RMN stated Resident 1 is a fall risk, can result in the resident attempting to get up and hurt themselves because their hands are tied, would not be able to catch themselves if falling. The RMN stated can be a potential for Resident 1 not to be able to drink as well. The RMN stated a COC was conducted during IDT on 1/16/2026 and that is when we notified the MD regarding the restlessness and that is when we obtained and order for labs and Resident 1 and was later noted with a UTI. The RMN stated COC form is to note a change in condition in the residents and to conduct and assessment on the resident. The RMN stated there is no COC for 1/14/2026.During an interview on 2/2/2026 at 3:19 p.m. with the DON stated was informed by LVN 1 on 1/14/2026 at 7:30 a.m. she had something important to tell them, LVN 1 stated let me show you a picture of a resident who was bound on her wrist and that is when LVN1 showed us the picture. The DON stated the picture showed Resident 1 bound by her wrist side by side with a greenish scarf, to me (DON) could not tell how tight it was but it looked solid there was no way the Resident 1 could have pulled arms apart. The DON stated this is physical abuse, used as a physical restraint, Resident 1 could have encouraged the potential for an injury from a fall due to her lack of mobility as her wrist were tied. The DON stated alleged abuse is considered a COC. The DON stated COC is a communication is a form that communicates with all staff, would have been given to nurses then, communicate to MD, IDT and family. The DON stated if there is no COC for 1/14/2026 allegation of abuse documented then we cannot say the MD, or family were notified of the COC.During a concurrent interview and record review on 2/3/2026 at 9:52 a.m. of Resident 1's Health Status Note with the RMN, the RMN stated there is no COC for Resident 1 on 1/14/2026. The RMN stated the COC would have been specifically for abuse and include the restlessness the restlessness was addressed on the OCC dated 1/16/2026. The RMN stated COC identity the COC, then will initiate 72- hour monitoring. The RMN stated the RN supervisor should have started the COC on 1/14/2026. The RMN reviewed Resident 1's Health Status Note dated 1/16/2026 at 7:25 a.m. and the RMN stated that is when the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	72-hour monitoring was started. The RMN stated 72-hour monitoring should have started on 1/14/2026. The RMN stated the 72 hour monitoring is to ensure residents are being checked for their psychosocial wellbeing and any new skin issues like bruising from the restraint and the resident's overall status. The RMN stated there was a delay in Resident 1's restlessness, RMN stated on 1/16/2026 when she spoke to MD1 asked if it was possible for Resident 1 to have a UTI. The RMN stated MD1 was notified but he had no orders at the time and 1/14/2026. The RMN stated basic nursing if not documented cannot say MD was notified, the RMN stated there is no documentation MD was notified on 1/14/2026.During a review of the facility's policy and procedure (P&P) titled, Change of Condition Notification, last reviewed on 7/28/2025, the P&P indicated to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. II. The facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal representative when the resident endures a significant change in their condition caused by, but not limited to:b. A significant change in the resident's physical, cognitive, behavioral or functional statusDocumentationA. A Licensed Nurse will document the following:i. Date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes.ii. The time the Attending Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received. iii. The time the family/responsible person was contactediv. Update the Care Plan to reflect the resident's current statusv. The incident and brief detail in the 24-hour report C. A Licensed Nurse will document each shift for at least seventy-two (72) hours.