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	02/25/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure confidential personal information for one of four sampled residents (Resident 4) was protected. The medical records of Resident 4 were left unattended on the medication cart computer. This deficient practice had the potential to violate Resident 4's rights for privacy and confidentiality of personal and medical records.Findings: During a review of Resident 4's admission Record (undated), the admission Record indicated the facility admitted the resident on 2/19/2026 with diagnoses including atherosclerotic heart disease (the buildup of fats, cholesterol, and other substances in and on the artery walls), gastroesophageal reflux disease (a condition in which the stomach contents leak backward from the stomach into the esophagus [the tube connecting the mouth and stomach]), and age-related osteoporosis (a disease that makes bones thin, weak, and brittle, increasing the risk of fractures [broken bones]). During an observation on 2/25/2026 at 9:58 a.m., observed the medication cart computer at nurse station 1 was open with Resident 4's medical record on the computer screen. Resident 4's visible medical records included the resident's name, picture, and medication list. Observed facility staff walked past the medication cart computer with Resident 4's medical information on it. During a concurrent observation and interview on 2/25/2026 at 10:02 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 4's medical records were observed on the medication cart computer. LVN 2 stated she did not lock the medication cart computer before she left to assist another resident. LVN 2 stated Resident 4's medical information was visible to the people walking on station 1 hallway. LVN 2 stated Resident 4's medical records left unattended had the potential to violate resident confidentiality. During an interview on 2/25/2026 at 3:30 p.m. with the Director of Nursing (DON), the DON stated Resident 4's medical records should not be left unattended. The DON stated facility staff not involved in Resident 4's care, other residents, and visitors had the potential for unauthorized access to Resident 4's medical records. The DON stated the facility failed to ensure private information in Resident 4's medical records was safe from unauthorized access. During a record review of the facility's policy and procedure (PnP) titled, General Provisions, last reviewed on 1/26/2026, the PnP indicated protected health information contained in the record is confidential and will only be released accordance with the facility's HIPPA policies. The PnP indicated active records are to be located in an area not accessible to unauthorized persons.

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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(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 ensure a comprehensive, person-centered care plan with measurable objectives and interventions for one of three sampled residents (Resident 1) was created and implemented. The facility failed to develop and implement an individualized care plan with interventions addressing Resident 1's change of condition (COC) on 2/9/2026. This deficient practice had placed Resident 1 at risk for not receiving the necessary services and assistance that can result in resident injury or serious condition such as worsening of Resident 1's right hip fracture and pain.Findings: During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted the resident on 3/3/2025 with diagnoses including age-related osteoporosis (a disease that makes bones thin, weak, and brittle, increasing the risk of fractures [broken bones]), unspecified dementia (a decline in brain function including memory, language, reasoning, and behavior severe enough to interfere with daily life but the specific type had not been identified), and essential hypertension (high blood pressure that is not due to another medical condition). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/24/2025, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was severely impaired. During a review of Resident 1's COC Evaluation, dated 2/9/2026, the COC Evaluation indicated Resident 1 complained of right hip pain. The COC Evaluation indicated Resident 1 was given Tylenol for the right hip pain. The COC Evaluation indicated on 2/9/2026 at 2:45 p.m., Resident 1's Attending Physician (MD) 1 was notified and ordered a right hip x-ray (a medical imaging that uses radiation to take pictures of the inside of a body). During an interview on 2/24/2026 at 3:15 p.m., and concurrent record review of Resident 1's Care Plans, reviewed with Registered Nurse (RN) 1, RN 1 stated Resident 1 complained of right hip pain on 2/9/2026. RN 1 stated there was no care plan created for Resident 1's COC on 2/9/2026. RN 1 stated a care plan should be initiated to address Resident 1's right hip pain. RN 1 stated if Resident 1's care plan was not created, the facility staff will not be aware of the interventions to address the resident's COC. During an interview on 2/25/2026 at 3:30 p.m. with the Director of Nursing (DON), the DON stated a care plan was a list of care and services to be provided for the residents. The DON stated a care plan should be created after Resident 1's COC on 2/9/2026. The DON stated Resident 1 did not have a care plan that included Resident 1's right hip pain. The DON stated Resident 1's care had the potential to lack interventions to prevent further injuries and manage the resident's pain. The DON stated the facility failed to ensure Resident 1 had a care plan after the resident's COC on 2/9/2026 that addressed the resident's right hip pain. During a review of the facility's policy and procedure (PnP) titled, Care Planning, last reviewed on 1/26/2026, the PnP indicated the purpose to ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. The PnP indicated each resident's comprehensive care plan will describe the. services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. During a review of the facility's PnP titled, Change of Condition Notification, last reviewed on 1/26/2026, the PnP indicated a licensed nurse will. update the Care Plan to reflect the resident's current status.

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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 follow professional standards of practice for one of three sampled residents (Resident 1) by failing to:1. Ensure licensed nurses monitored Resident 1's medical status after the resident's change of condition (COC) on 2/9/2026. Resident 1's COC status was not monitored on 2/9/2026, 11 p.m. to 7 a.m. shift.2. Ensure Registered Nurse (RN) 1 assessed Resident 1's right lower extremity after the resident complained of right hip pain. These deficient practices had the potential to place Resident 1 at risk for undetected and worsening medical conditions which could negatively impact the residents' health and safety.Findings: During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted the resident on 3/3/2025 with diagnoses including age-related osteoporosis (a disease that makes bones thin, weak, and brittle, increasing the risk of fractures [broken bones]), unspecified dementia (a decline in brain function including memory, language, reasoning, and behavior severe enough to interfere with daily life but the specific type had not been identified), and essential hypertension (high blood pressure that is not due to another medical condition). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/24/2025, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was severely impaired. During a review of Resident 1's COC Evaluation, dated 2/9/2026, the COC Evaluation indicated Resident 1 complained of right hip pain. The COC Evaluation indicated Resident 1 was given Tylenol for the right hip pain. The COC Evaluation indicated on 2/9/2026 at 2:45 p.m., Resident 1's Attending Physician (MD) 1 was notified and ordered a right hip x-ray (a medical imaging that uses radiation to take pictures of the inside of a body). During an interview on 2/24/2026 at 3:15 p.m., and concurrent record review of Resident 1's medical records, reviewed with RN 1, RN 1 stated Resident 1's COC Evaluation, dated 2/9/2026, indicated on 2/9/2026 at 2:40 p.m., Resident 1 complained of right hip pain. RN 1 stated Resident 1's COC should be monitored every shift for 72 hours. RN 1 stated Resident 1's Progress Notes indicated there was no documented evidence that the resident was monitored on 2/9/2026 (11 p.m. to 7 a.m. shift). RN 1 stated she did not document her full assessment of Resident 1's right lower extremity on the resident's Progress Notes. RN 1 stated a resident care that was not documented was considered as not done. RN 1 stated incomplete documentation of Resident 1's health status had the potential for the resident's health condition to worsen. During an interview on 2/25/2026 at 3:30 p.m. with the Director of Nursing (DON), the DON stated Resident 1 should be monitored every shift for at least 72 hours after the resident's COC. The DON stated there was no documented evidence that Resident 1 was monitored on 2/9/2026, 11 p.m. to 7 a.m. shift. The DON stated RN 1 did not document the assessment done on Resident 1's lower extremities that included pain on palpation and the appearance of the right lower extremity. The DON stated that if resident care was not documented it meant the resident care was not done. The DON stated not assessing and monitoring the resident after a COC had the potential for the resident's progress or decline to be missed. The DON stated the facility failed to provide safe resident care by failing to ensure Resident 1 was assessed and monitored after a COC. During a review of the facility's policy and procedure (PnP) titled, Change of Condition Notification, last reviewed on 1/26/2026, the PnP indicated the licensed nurse will assess the resident's change of condition and document the observations and symptoms. The PnP indicated a licensed nurse will document the. date, time, and pertinent details of the incident and the subsequent assessment in the nursing notes. The PnP indicated a licensed nurse will document each shift for at least seventy-two (72) hours.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure the medical records of one of three sampled residents (Resident 1) was maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to:1. Ensure Registered Nurse (RN) 1 documented the level of care provided to Resident 1 while the resident was in the facility. RN 1 documented the level of care and assessment she provided to Resident 1 on 2/10/2026. Resident 1 had a change of condition (COC) on 2/9/2026.2. Ensure social service staff documented the level of care provided to Resident 1 while the resident was in the facility. Social service staff documented Resident 1 was transferred to the General Acute Care Hospital (GACH) 1 on 2/9/2026. Resident 1 was transferred to GACH 1 on 2/10/2026. 3. Ensure Licensed Vocational Nurse (LVN) 1 documented the Tylenol oral tablet (a medication taken by mouth used to temporarily relieve minor aches, pain, and reduce fever) 650 milligrams (mg - unit of measurement) given to Resident 1 in the resident's medication administration record (MAR).These deficient practices resulted in incomplete and inaccurate information on Resident 1's medical records and had the potential for delayed medical interventions.Findings: During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted the resident on 3/3/2025 with diagnoses including age-related osteoporosis (a disease that makes bones thin, weak, and brittle, increasing the risk of fractures [broken bones]), unspecified dementia (a decline in brain function including memory, language, reasoning, and behavior severe enough to interfere with daily life but the specific type had not been identified), and essential hypertension (high blood pressure that is not due to another medical condition). During a review of Resident 1's Physician Orders, dated 3/3/2025, the Physician Orders indicated Tylenol oral tablet 325 mg, give two tablets every four hours as needed for mild pain or general discomfort. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/24/2025, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was severely impaired. During a review of Resident 1's COC Evaluation, dated 2/9/2026, the COC Evaluation indicated Resident 1 complained of right hip pain. The COC Evaluation indicated Resident 1 was given Tylenol for the right hip pain. The COC Evaluation indicated on 2/9/2026 at 2:45 p.m., Resident 1's Attending Physician (MD) 1 was notified and ordered a right hip x-ray (a medical imaging that uses radiation to take pictures of the inside of a body). During a review of Resident 1's COC Evaluation, dated 2/10/2026, the COC Evaluation indicated the facility received Resident 1's x-ray results. The COC Evaluation indicated on 2/10/2026 at 8:05 a.m., Resident 1's Attending Physician (MD) 1 was notified and ordered to transfer the resident to GACH 1. During an interview on 2/24/2026 at 3:15 p.m., and concurrent record review of Resident 1's Progress Notes, dated 2/9/2026 to 2/10/2026, reviewed with RN 1, RN 1 stated she assessed Resident 1 after the resident's COC on 2/9/2026. RN 1 stated Resident 1's Progress Notes indicated she documented her assessment of the resident's COC on 2/10/2026. RN 1 stated Resident 1's Progress Notes did not indicate the assessment documented on 2/10/2026 was a late entry for the assessment done on 2/9/2026. RN 1 stated the documented assessment on Resident 1's Progress Notes was not timely and was not accurate. RN 1 stated Resident 1's Progress Notes, dated 2/10/2026, indicated social services documented the resident was transferred to GACH 1 on 2/9/2026. RN 1 stated Resident 1 was transferred to GACH 1 on 2/10/2026. RN 1 stated the social services documentation on Resident 1's transfer to GACH 1 was inaccurate. RN 1 stated on 2/9/2026, she witnessed LVN 1 giving Resident 1 two tablets of Tylenol 325 mg. RN 1 stated there was no documented evidence on Resident 1's MAR, dated 2/1/2026 to 2/28/2026, that Resident 1 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received two tablets of Tylenol 325 mg on 2/9/2026. During an interview on 2/25/2026 at 3:30 p.m. with the Director of Nursing (DON), the DON stated RN 1 did not timely document Resident 1's assessment after the COC on 2/9/2026. The DON stated Resident 1's Progress Notes, dated 2/10/2026, should indicate RN 1's documented assessment was a late entry for 2/9/2026. The DON stated Resident 1 was transferred to GACH 1 on 2/10/2026. The DON stated the social services documentation should indicate the correct date of Resident 1's transfer to GACH 1. The DON stated inaccurate documentation had the potential to cause confusion amongst the care team that may negatively affect resident care. The DON stated inaccurate documentation of Resident 1's transfer to GACH 1 had the potential to cause confusion on the resident's 7-day bed hold. The DON stated Resident 1's MAR did not indicate the two tablets of Tylenol 325 mg were given to Resident 1 on 2/9/2026. The DON stated another licensed nurse may give another dose of Tylenol that may potentially cause Resident 1 to overdose. The DON stated the facility failed to provide safe care to Resident 1 by failing to document the resident assessment timely. The DON stated the facility failed to document accurately the date Resident 1 was transferred to GACH 1. The DON stated the facility failed to ensure the pain medication given to Resident 1 was documented in the resident's MAR. During a review of the facility's policy and procedure (PnP) titled, Documentation - Nursing, last reviewed on 1/26/2026, the PnP indicated the purpose to provide documentation of resident status and care given by nursing staff. The PnP indicated . F. nurse's notes are dated, timed, and signed when written. H. medication administration records and treatment administration records are completed with each medication or treatment completed. K. documentation will be completed by the end of the assigned shift. During a review of the facility's PnP titled, Medication - Administration, last reviewed on 1/26/2026, the PnP indicated the purpose to provide standards for safe administration of medications for residents in the facility. The PnP indicated the time and dose of the drug or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administers the drug or treatment. During a review of the facility's PnP titled, Completion & Correction, last reviewed on 1/26/2026, the PnP indicated the purpose to ensure that medical records are complete and accurate. The PnP indicated . II. entries will be recorded promptly as the events or observations occur, III. Entries will be complete, legible, descriptive and accurate. V. when adding an entry at a later date, the entry is to be clearly identified as a late entry, late entries should be documented as soon as possible. VII. Documentation will reflect medically relevant information concerning the resident and will be documented in a professional manner.