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	05/21/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for four of nine sampled residents (Residents 3, 4, 6, and 8) by failing to:1. Implement Resident 3's care plan on risk of anti-hypertensive medication (medications used to treat hypertension [HTN-high blood pressure]).2. Develop a care plan for Resident 4's use of hydrogel (promotes wound healing by maintaining a moist environment, cooling the skin, and softening dead tissue to allow the body to naturally clear it away).3. Implement Resident 6's care plan on enhanced barrier precaution (EBP- an infection control method used in nursing homes to prevent the spread of hard-to-treat germs, like antibiotic-resistant bacteria).4. Develop a care plan for Resident 8's right heel deep tissue injury (DTI-a serious form of pressure sore where the soft tissue under intact skin is damaged).These failures had the potential for delays in the delivery of necessary care and services and could place Resident 3 at risk for HTN, Residents 4 and 8 at risk for worsening of pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence,) and Resident 6 at risk for infection. Findings:a. During a review of Resident 3?s admission Record, the admission Record indicated the facility admitted Resident 3 on 8/13/2025, with diagnoses that included essential HTN.During a review of Resident 3's Care Plan, dated 8/14/2025, on antihypertensive medication, the Care Plan indicated the following interventions:1. Hold metoprolol (medication used to lower HTN) for systolic blood pressure (sbp- measures the maximum pressure inside your arteries when your heart beats and pushes blood out into your body) less than 120 millimeters mercury (mmHg-a standard unit of measurement for pressure).2. Administer medications as ordered per given parameters (specific, measurable conditions, limits, or guidelines set by a doctor that direct nurses or caregivers on how and when to administer a treatment or medication).During a review of Resident 3's Order Audit Report, dated 4/20/2026, the Order Audit Report indicated metoprolol tartrate tablet 12.5 milligram (mg- metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth two times a day for HTN, hold for sbp less than 120 mmHg.During a review of Resident 3's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 4/21/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS-a resident assessment tool), dated 4/27/2026, the MDS indicated Resident 3's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired.During a review of Resident 3's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 5/2026, the MAR indicated metoprolol was administered on the following dates:1. Licensed Vocational Nurse 4 (LVN 4) administered on 5/1/2026, at 5 p.m. with a blood pressure of 119/76 mmHg,2. LVN 4 administered on 5/2/2026, at 5 p.m. with a blood pressure of 115/69 mmHg.3. LVN 4 administered on 5/5/2026, at 5 p.m. with a blood pressure of 117/79 mmHg.4. LVN 5 administered on 5/7/2026, at 9 a.m. with a blood pressure of 115/75 mmHg.During an interview on (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/19/2026, at 11:29 a.m., with LVN 5, LVN 5 stated he (LVN 5) should have held the metoprolol as per physician order. LVN 5 stated Resident 3's care plan was not followed.During an interview on 5/21/2026, at 12:05 p.m., with the Risk Management Nurse (RMN), the RMN stated Resident 3's care plan for HTN was not followed. The RMN stated care plans are guides on how to care for the residents. The RMN stated if care plan is not followed, Resident 3 would be at risk for hypotension (low blood pressure).b. During a review of Resident 4?s admission Record, the admission Record indicated the facility admitted Resident 4 on 3/13/2026, with diagnoses that included unspecified (unconfirmed) respiratory failure (occurs when the lungs cannot get enough oxygen into the blood or fail to remove excess carbon dioxide), unspecified dementia (a progressive state of decline in mental abilities) and generalized muscle weakness.During a review of Resident 4's H&P, dated 3/14/2026, the H&P indicated Resident 4 had the capacity to understand and make decisions.During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills for daily decisions were intact.During a review of Resident 4's Order Recap Report, dated 5/6/2026, the Order Recap Report indicated zinc oxide (a medicated cream, ointment or paste that treats or prevents skin irritation like cuts, burns or diaper rash) ointment 10 percent (%-for every 100) to left buttocks stage two pressure ulcer (partial-thickness loss of skin, presenting as a shallow open sore or wound) twice a day.During a review of Resident 4's Progress Notes, dated 5/11/2026, the Progress Notes indicated the Wound Care Provider (WCP) came and assessed Resident 4's pressure ulcer. The Progress Notes indicated the treatment for stage two left buttocks was changed to hydrogel daily.During a review of Resident 4's Treatment Administration Record (TAR), dated 5/2026, the TAR indicated the Treatment Nurses (TNs) applied zinc oxide to Resident 4's left buttocks twice a day from 5/11/2026, to 5/14/2026.During a concurrent observation on 5/19/2026, at 9:20 a.m., with TN 1, at Resident 4's bedside, TN 1 applied zinc oxide to Resident 4's left buttocks pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence).During a concurrent interview and record review on 5/19/2026, at 10:42 a.m. with TN 1, Resident 4's WCP Progress Notes, dated 5/11/2026, was reviewed. TN 1 stated she (TN 1) had applied zinc oxide to Resident 4's left buttocks stage two pressure injury. TN 1 stated she (TN 1) should have used hydrogel as per WCP order since 5/11/2026. TN 1 stated using medication not ordered by the WCP can slow the healing process of Resident 4's pressure injury.During a concurrent interview and record review on 5/19/2026, at 12:14 p.m., with Care Planner 1 (CP 1), CP 1 stated there was no care plan developed for use of hydrogel because the hydrogel was not transcribed as a physician order.During an interview on 5/21/2026, at 12:05 p.m., with the RMN, the RMN stated care plan should reflect treatment orders that should be provided to residents. The RMN stated hydrogel should have been transcribed in the physician order, treatment should have been initiated, and CPs should have been notified so they (CP) could have developed a care plan for the use of hydrogel. The RMN stated that without the care plan for the use of hydrogel, there was no appropriate treatment for Resident 4's stage two pressure injury and could worsen the pressure injury.c. During a review of Resident 6?s admission Record, the admission Record indicated the facility admitted Resident 6 on 3/31/2025, with diagnoses that included chronic respiratory failure, and history of fall.During a review of Resident 6's H&P, dated 9/22/2025, the H&P indicated Resident 6 had fluctuating capacity to understand and make decisions.During a review of Resident 6's Care Plan, dated 10/28/2025, on EBP, the Care Plan indicated an intervention to use gown and gloves during high contact resident care activities (dressing, bathing, transfers, hygiene, toileting, brief changes, changing linens, device care, wound care).During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 6 was dependent on staff for ADL. The MDS indicated Resident 6 had one stage two pressure ulcers, and three unstageable pressure ulcers (a severe full-thickness skin and tissue loss where the true depth of the damage cannot be assessed).During an observation on 5/15/2026, at 1:37 p.m., outside of Resident 6's room, an EBP signage posted by the door and an isolation cart with gloves, gown and mask observed. Resident 6's (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	door was open and curtain was pulled close.During an observation on 5/15/2026, at 1:38 p.m., inside Resident 6's room, Resident 6 lying in bed with urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) hanging to the right side of the bed covered with a dignity bag. Observed CNA 1 standing on the left side of Resident 6 providing bed bath.During a concurrent observation and interview on 5/15/2026, at 1:39 p.m. with CNA 1 at Resident 6 bedside. CNA 1 stated she (CNA 1) provided bed bath to Resident 6 who had a urinary catheter. CNA 1 stated she (CNA 1) did not wear a gown and should have worn a gown before providing bed bath.During a concurrent interview and record review on 5/19/2026, at 12:14 p.m., with CP 1, Resident 6's care plans were reviewed. CP 1 stated the Care Plan, dated 10/28/2025, for EBP indicated an intervention to use gown and gloves during high contact resident care activities. CP 1 stated care plan for EBP was not followed if CNA did not wear a gown while providing bed bath.During an interview on 5/21/2026, at 12:05 p.m., with the RMN, the RMN stated care plans are guides that nurses should follow to prevent spread of infection.d. During a review of Resident 8's admission Record, the admission Record indicated the facility admitted Resident 8 on 2/20/2026, with diagnoses that included metabolic encephalopathy (when the brain temporarily stops working properly because of a chemical problem or imbalance in the rest of your body) and right heel stage three pressure injury (Full-thickness loss of skin. Dead and black tissue may be visible).During a review of Resident 8's H&P, dated 2/20/2026, the H&P indicated Resident 8 did not have the capacity to understand and make decisions.During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8's cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 8 had one stage three pressure injury.During a review of Resident 8's Progress Notes, dated 5/11/2026, the Progress Notes indicated the WCP assessed and documented Resident 8 with unstageable upper mid back and right heel DTI.During a concurrent interview and record review on 5/19/2026, at 12:14 p.m., with CP 1, Resident 8's Progress Notes, dated 5/11/2026, and Care Plans were reviewed. CP 1 stated the WCP assess Resident 8 on 5/11/2026 and documented right heel DTI. CP 1 stated the WCP notes were not relayed to CPs reason why no care plan was developed for right heel DTI.During an interview on 5/20/2026, at 11:29 a.m., with Registered Nurse 1 (RN 1), RN 1 stated care plan should have been developed for Resident 8's right heel DTI.During an interview on 5/21/2026, at 12:05 p.m., with the RMN, the RMN stated no care plan was developed for Resident 8 after the WCP reclassified right heel from stage three to DTI. The RMN stated care plan should have been developed to treat Resident 8's current pressure injury.During a review of facility's policy and procedure (P&P), titled, Wound Management, dated 11/1/2017, and last reviewed on 1/26/2026, the P&P indicated, If the Wound Monitoring Record is not used, documentation will be recorded within the medical record which may include nursing notes, treatment records or care plans.Implement a wound treatment per physician's order. A Licensed Nurse will develop a Care Plan for the resident based on recommendations from Dietary, Rehabilitation and the Attending Physician. Update the resident's Care Plan as necessary.During a review of facility's P&P, titled, Care Planning, dated 3/7/2025, and last reviewed on 1/26/2026, the P&P indicated, To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs.2. The Care Plan serves as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's Attending Physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs.3. A Licensed Nurse will initiate the Care Plan, and the plan will be finalized in accordance with MDS guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgment on an ass needed bases.9. Each resident's Comprehensive Care Plan will describe the following:A. 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 facility's P&P, titled, Pressure Ulcer Prevention, dated 2/1/2015, and last reviewed on 1/26/2026, the P&P indicated, The Care Plan will be revised as indicated.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents received care consistent with professional standards of practice for two of nine sampled residents (Residents 1 and 9) by failing to:1. Ensure the Physician was notified of Resident 1's blood sugar over 250 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) per deciliter (dl- a metric unit of volume equal to one-tenth of a liter) on 4/17/2026, to 4/19/2026, as per physician order.2. Ensure Resident 9's fluid restriction of one liter per day was followed as per physician order.These failures had the potential to place Resident 1 at risk for hyperglycemia (high blood sugar) and for Resident 9 at risk for fluid overload.Findings:a. During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 1/20/2026, with diagnoses that included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities).During a review of Resident 1's Order Summary Report, dated 1/20/2026, the Order Summary Report indicated fasting blood sugar fingerstick check (FBS- using a small, portable device to check a resident's current blood glucose level by pricking their fingertip) two times a day, notify the physician if blood sugar is less than 70 mg/dl or more than 250 mg/dl.During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 1/21/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 1/27/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired.During a review of Resident 1's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 4/2026, the MAR indicated the following:1. 4/17/2026, at 7 a.m.- 275 mg/dl2. 4/18/2026, at 5 p.m.- 285 mg/dl3. 4/19/2026, at 7 a.m.- 254 mg/dlDuring a review of Resident 1's Progress Notes, dated 4/17/2026, to 4/19/2026, the Progress Notes did not indicate documentation of physician notification for blood sugar over 250 mg/dl.During an interview on 5/19/2026, at 1:27 a.m., with Assistant Director of Staff Development 1 (ADSD 1), ADSD 1 stated he (ADSD 1) might have forgotten to document physician notification of elevated blood sugar on 4/17/2026, at 7 a.m. ADSD 1 stated if no documentation it means physician was not notified. ADSD 1 stated 275 mg/dl is a high blood sugar and the physician should have been notified to prevent episode of hyperglycemia.During an interview on 5/20/2026, at 10:42 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated if there was no documentation of physician notification, it means physician was not notified of Resident 1's elevated blood sugar of over 250 mg/dl. LVN 1 stated it is important to notify the physician accordingly to modify the plan of care and for immediate action to prevent hyperglycemia.During a concurrent interview and record review on 5/20/2026, at 11:29 a.m., with Registered Nurse 1 (RN 1), Resident 1's Physician Order, dated 1/20/2026, MAR, and Progress Notes, dated 4/17/2026 to 4/19/2026, were reviewed. RN 1 stated if ADSD 1, LVN 1 and LVN 2 had called the physician they should have documented in the Progress Notes. RN 1 stated ADSD 1, LVN 1 and LVN 2 should have followed the physician order to notify if Resident 1's blood sugar was over 250 mg/dl to prevent hyperglycemia that could result in uncontrolled blood sugar. During an interview on 5/21/2026, at 12:05 p.m., with the Risk Management Nurse (RMN), the RMN stated ADSD 1, LVN 1 and LVN 2 should have notified the physician according to physician order. The RMN stated if physician not notified, Resident 1 would not receive appropriate medication to lower the blood sugar. The RMN stated Resident 1 could experience hyperglycemia.During a review of facility's policy and procedure (P&P) titled, Diabetic Care, dated 8/1/2014,and last reviewed on 1/26/2026, the P&P indicated, In any case where the resident's blood sugar is less than 70 or greater than 350, the Attending Physician must be notified; unless otherwise (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	noted on the Physician's order.Document the episode in the resident's medical record including: .D. Physician notification.b. During a review of Resident 9?s admission Record, the admission Record indicated the facility admitted Resident 9 on 4/5/2023, with diagnoses that included chronic combined congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic kidney disease stage 4 (kidneys are severely damaged and operating at 15 percent [%] to 29% capacity. It is the final stage before kidney failure), and unspecified pulmonary hypertension (high blood pressure in the blood vessels that supply the lungs). During a review of Resident 9's Physician Order, dated 6/15/2024, the Physician Order indicated 1,000 milliliters (ml- a metric unit of volume equal to one-thousandth of a liter) daily fluid restriction.During a review of Resident 9's H&P, dated 3/20/2026, the H&P indicated Resident 9 did not have the capacity to understand and make decisions.During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9's cognitive skills for daily decisions were intact. The MDS indicated Resident 9 was on diuretic (sometimes called water pills, help remove extra fluid from the body).During a review of Resident 9's Order Review History Report, dated 4/9/2026, the Order Review History Report indicated the following orders:1. Bumetanide (medication used to eliminate excess fluid buildup in the body) tablet 2 mg, give one tablet by mouth daily for fluid retention.2. Metolazone (medication used to eliminate excess fluid buildup in the body) tablet 2.5 mg, give one tablet by mouth daily for water retention. During a review of Resident 9's MAR, dated 4/2026, the MAR indicated the following daily fluid intake:1. 4/1/26, 1300 ml2. 4/5/26, 1300 ml3. 4/9/26, 1100 ml4. 4/10/26, 1300 ml5. 4/11/26, 1100 ml6. 4/14/26, 1300 ml7. 4/16/26, 1300 ml8. 4/18/26, 1500 ml9. 4/19/26, 1300 ml10. 4/20/26, 1200 ml11. 4/21/26, 1200 mlDuring a concurrent interview and record review on 5/20/2026, at 11:29 a.m., with RN 1, Resident 9's Physician Order, dated 6/15/2024, and MAR, dated 4/2026, were reviewed. RN 1 stated bumetanide and metolazone are both diuretics and Resident 9was on fluid restriction of 1,000 ml a day. RN 1 stated there were 11 days in Resident 9's MAR, dated 4/2026, that Resident 9 received more than 1,000 ml a day. RN 1 stated nurses should follow the physician order. RN 1 stated Resident 9 could have pulmonary edema (a dangerous buildup of fluid in the lungs) from excess fluid intake.During an interview on 5/21/2026, at 12:05 p.m., with the RMN, the RMN stated nurses should have documented accurately and follow the physician order. The RMN stated Resident 9 could have fluid overload.During a review of facility's policy and procedure (P&P) titled, Physician Orders, dated 5/1/2019, and last reviewed on 1/26,2026, the P&P indicated, Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents received care consistent with professional standards of practice to prevent pressure injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence) for three of nine sampled residents (Residents 3, 4, and 6) by failing to:1. Ensure Treatment Nurse 1 (TN 1) provided wound treatment to Resident 3's pressure injuries on 5/14/2026.2. Ensure TN 1 assessed Resident 3's skin accurately on 5/10/2026.3. Ensure accurate treatment was provided to Resident 4 from 5/11/2026, when the physician changed the treatment from zinc oxide (a medicated cream, ointment or paste that treats or prevents skin irritation like cuts, burns or diaper rash) to hydrogel (promotes wound healing by maintaining a moist environment, cooling the skin, and softening dead tissue to allow the body to naturally clear it away).4. Ensure TN 2 assessed Resident 4's skin accurately on 5/7/2026.5. Ensure TN 1 assessed Resident 4's skin weekly and documented on 5/14/2026.6. Ensure TN 1 provided wound treatment to Resident 6's pressure injuries on 5/14/2026.These failures had the potential for the development and worsening of Residents 3, 4 and 6's pressure injuries.Findings:a. During a review of Resident 3?s admission Record, the admission Record indicated the facility admitted Resident 3 on 8/13/2025, with diagnoses that included vascular (having to do with the blood vessels and circulation) dementia (a progressive state of decline in mental abilities), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial weakness, heaviness, or numbness on just one entire side of your body) following cerebral infarction (a critical medical emergency caused by a blocked or narrowed blood vessel in the brain).During a review of Resident 3's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 4/21/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS-a resident assessment tool), dated 4/27/2026, the MDS indicated Resident 3's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 3 was dependent on staff for all activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 3's Change of Condition (COC- a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated 5/2/2026, the COC indicated unstageable (a severe full-thickness skin and tissue loss where the true depth of the damage cannot be assessed) right heel pressure injury and the physician ordered Santyl (medication used to remove dead tissue from chronic skin ulcers [open, crater-like sores that develop when the skin breaks down and underlying tissue is exposed] and severe burns) ointment 250 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount) daily.During a review of Resident 3's Order Recap Report (Physician Order), dated 5/8/2026, the Order Recap Report indicated the following orders:1. Hydrogel wound dressing to sacral-coccyx (tailbone) right buttocks topically (applying something directly to the surface of the body), daily and as needed for excoriation (a scrape or scratch to the skin).2. Santyl external ointment 250 units per gram, apply to left inner knee topically daily for unstageable pressure injury and cover with collagen dressing (an advanced medical bandage made from natural proteins that promotes wound healing).During a review of Resident 3's Treatment Administration Record (TAR- flowsheet that indicates treatment given to a resident), dated 5/2026, the TAR indicated on 5/14/2026, treatment for right heel, right buttocks and left inner knee were left blank.During a concurrent interview and record review on 5/19/2026, at 10:26 a.m., with TN 1, Resident 3's TAR, dated 5/2026, were reviewed. The TAR indicated blank treatment on 5/14/2026. TN 1 stated if TAR was left blank it means treatment was not provided. TN 1 stated she (TN 1) was the assigned TN to Resident 3 on 5/14/2026.During an interview on 5/20/2026, at 11:29 p.m., with Registered Nurse 1 (RN 1), RN 1 stated if TAR was left blank it means treatment was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not provided. RN 1 stated if treatment is not provided a pressure injury can worsen.During an interview on 5/21/2026, at 12:05 p.m., with the RMN, the RMN stated TNs should provide the treatment according to the physician order and document that treatment was provided. The RMN stated if left blank it means TNs did not change the residents dressing. The RMN stated residents' pressure injuries can worsen.b. During a review of Resident 3's COC, dated 5/8/2026, the COC indicated unstageable pressure injury to left inner knee and left buttocks.During a review of Resident 3's Skin Check, dated 5/10/2026, the Skin Check only indicated right heel unstageable pressure injury.During a concurrent interview and record review on 5/21/2026, at 11:20 a.m., with TN 1, Resident 3's COC, dated 5/8/2026, and Skin Check, dated 5/10/2026, were reviewed. TN 1 stated she (TN 1) did not include the unstageable pressure injury on the left inner knee and left buttocks from the 5/8/2026 COC to the Skin Check, dated 5/10/2026. TN 1 she (TN 1) should have completely documented all pressure injuries to show that skin assessment was done thoroughly. TN 1 stated it resulted in Resident 3's inaccurate skin assessment. During an interview on 5/21/2026, at 12:05 p.m. with the RMN, the RMN stated TNs should do a weekly skin check to assess residents' skin for any new and ongoing skin issues. The RMN stated that because Resident 3's skin was not accurately assessed, Resident 3's pressure injury can worsen.c. During a review of Resident 4?s admission Record, the admission Record indicated the facility admitted Resident 4 on 3/13/2026, with diagnoses that included unspecified (unconfirmed) respiratory failure, unspecified dementia and generalized muscle weakness.During a review of Resident 4's H&P, dated 3/14/2026, the H&P indicated Resident 4 had the capacity to understand and make decisions.During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills for daily decisions were intact.During a review of Resident 4's Order Recap Report, dated 5/6/2026, the Order Recap Report indicated zinc oxide ointment 10 percent (%-for every 100) to stage two left buttocks pressure injury twice a day.During a review of Resident 4's Progress Notes, dated 5/11/2026, the Progress Notes indicated the Wound Care Provider (WCP) came and assessed Resident 4's pressure injury. The Progress Notes indicated the treatment for stage two left buttocks was changed to hydrogel daily.During a review of Resident 4's TAR, dated 5/2026, the TAR indicated zinc oxide applied to left buttocks twice a day from 5/11/2026 to 5/14/2026.During a concurrent observation and interview on 5/19/2026, at 9:20 a.m., with TN 1, at Resident 4's bedside, TN 1 was standing on Resident 4's right side while Registered Nurse 1 (RN 1) on the left side of Resident 4, assisting TN 1 with dressing change. Observed TN 1 cleansed Resident 4's stage two left buttocks pressure injury with saline (salt water) wet gauze, then TN 1 removed her (TN 1) gloves, used alcohol-based hand rub (often called hand sanitizer-is a liquid or gel used to quickly kill germs on your hands), don (put on) gloves, and dry wound with gauze. Observed TN 1 removed gloves, took a tongue depressor (a medical instrument made of wood), and used to apply zinc oxide to Resident 4's left buttocks pressure injury and applied a new foam dressing with no gloves.During a concurrent interview and record review on 5/19/2026, at 10:42 a.m. with TN 1, Resident 4's WCP Progress Notes, dated 5/11/2026, was reviewed. TN 1 stated she (TN 1) had applied zinc oxide to Resident 4's left buttocks stage two pressure injury. TN 1 stated she (TN 1) should have used hydrogel as per WCP order since 5/11/2026. TN 1 stated using medication not ordered by the WCP can slow the healing process of Resident 4's pressure injury.During an interview on 5/20/2026, at 11:29 a.m., with RN 1, RN 1 stated TNs should read the wound care notes and carry out the new orders. RN 1 stated hydrogel should have been applied to Resident 4's left buttocks since 5/11/2026, as per physician order.During an interview on 5/21/2026, at 12:05 p.m. with the RMN, the RMN stated TNs should check the WCP Progress Notes. The RMN stated not using the ordered treatment can result in Resident 4's wound regressing (to return to a former, usually less developed or worse) instead of improving.d. During a review of Resident 4's COC, dated 5/6/2026, the COC indicated stage two pressure injury to left buttocks.During a review of Resident 4's Skin Check, dated 5/7/2026, the Skin Check indicated below left elbow bruising. During a concurrent interview and record review on 5/21/2026, at 8:33 a.m., with TN 2, Resident 4's COC, (continued on next page)

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	555579	A. Building B. Wing	05/21/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 5/6/2026, and Skin check, dated 5/7/2026, were reviewed. TN 2 stated Skin Check on 5/7/2026, should include the COC on 5/6/2026, that Resident 4 had stage two pressure injury on the left buttocks. TN 2 stated Skin Check on 5/7/2026 was not complete. TN 2 stated Resident 4 had incomplete skin assessment on 5/7/2026.During an interview on 5/21/2026, at 12:05 p.m. with RMN, the RMN stated TNs should assess Resident 4 ?s skin weekly and document in the Skin Check. The RMN stated incomplete Skin Check indicated incomplete skin assessment. The RMN stated that incomplete skin assessment could potentially result in worsening of pressure injury.e. During a concurrent interview and record review on 5/21/2026, at 8:33 a.m., with TN 2, Resident 4's Skin Checks, dated 5/2026, were reviewed. TN 2 stated weekly skin check was performed to keep track of resident's skin, identify problem areas and notify the physician to obtain treatment. TN 2 stated latest documented Skin Check for Resident 4 was on 5/7/2026. TN 2 stated TN 1 was the assigned TN for Resident 4 on 5/14/2026, when Skin Check was not done. TN 2 stated there was no documented Skin Check on 5/14/2026. TN 2 stated there was a glitch (a brief, unexpected malfunction or temporary fault in a system) in the computer documentation that took out the skin check schedule.During an interview on 5/21/2026, at 9:45 a.m., with Information System (IS) staff, the IS stated Resident 4 was not affected by the glitch in skin check schedule.During an interview on 5/21/2026, at 12:05 p.m., with the RMN, the RMN stated TNs should assess residents' skin weekly and document findings. The RMN stated not doing a weekly skin check could potentially result in unidentified skin problems and could worsen pressure injury.f. During a review of Resident 6?s admission Record, the admission Record indicated the facility admitted Resident 6 on 3/31/2025, with diagnoses that included chronic respiratory failure, and history of fall.During a review of Resident 6's H&P, dated 9/22/2025, the H&P indicated Resident 6 had fluctuating capacity to understand and make decisions.During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 6 was dependent on staff for ADL. The MDS indicated Resident 6 had one stage two pressure injuries, and three unstageable pressure injuries.During a review of Resident 6's Order Review History Report, dated 4/20/2026, the Order Review History Report indicated cleanse coccyx stage two pressure injury with normal saline, gently pat dry, apply nickel thick Santyl ointment, then cover with foam dressing daily.During a review of Resident 6's Order Review History Report, dated 4/25/2026, the Order Review History Report indicated cleanse right buttocks unstageable pressure injury with normal saline, pat dry, apply Santyl and cover with foam dressing.During a review of Resident 6's Order Review History Report, dated 5/6/2026, the Order Review History Report indicated applying silver sulfadiazine (a prescription topical antibiotic primarily used to prevent and treat infections in severe second- and third-degree burns) cream one percent (%) to buttocks skin tear daily.During a review of Resident 6's Order Review History Report, dated 5/6/2026, the Order Review History Report indicated cleanse left heel deep tissue injury (DTI-a serious form of pressure sore where the soft tissue under intact skin is damaged) with normal saline, pat dry, paint betadine (used on the skin to treat or prevent skin infection in minor cuts, scrapes, or burns) 10% and cover with dry dressing and secure with tape.During a review of Resident 6's Order Review History Report, dated 5/13/2026, the Order Review History Report indicated cleanse left heel with normal saline, pat dry, apply Santyl, cover with foam dressing topically daily for unstageable pressure injury.During a review of Resident 6's TAR, dated 5/2026, the TAR indicated the treatment for following pressure injuries were left blank on 5/14/2026.1. coccyx stage two pressure injury with Santyl.2. left heel unstageable pressure injury with Santyl3. left heel DTI with betadine4. right buttocks unstageable with Santyl.5. left buttocks skin tear with silver sulfadiazineDuring a concurrent interview and record review on 5/19/2026, at 10:26 a.m., with TN 1, Resident 6's Physician Orders, dated 4/20/2026, 4/25/2026, 5/6/2026 and 5/13/2026, and TAR, dated 5/2026, were reviewed. TN 1 stated treatment for Resident 6's skin issues were left blank on 5/14/2026. TN 1 stated blank means treatment not provided since it was not documented.During an interview on 5/21/2026, at 12:05 p.m., with the RMN, the RMN stated a blank TAR indicated treatment (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was not provided. The RMN stated TN should provide the treatment per physician order and document. The RMN stated if treatment is not done, Resident 6's wounds can worsen.During a review of facility's policy and procedure (P&P) titled, Wound Management, dated 11/1/2017, and last reviewed on 1/26/2026, the P&P indicated, To provide a system for the treatment and management of residents with wounds including pressure and non-pressure ulcers. A resident who has a wound will receive necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing.1. AssessmentA. A Licensed Nurse will perform a skin assessment upon admission, readmission, weekly, and as needed for each resident.C. Implement a wound treatment per physician's order.2. Wound Management.Per Attending Physician order, the Nursing Staff will initiate treatment and utilize interventions for pressure redistribution and wound management.3. Documentation.B. Wound documentation will occur at a minimum of weekly until the wound is healed.During a review of facility's P&P titled, Pressure Ulcer Prevention, dated 2/1/2015, and last reviewed on 1/26/2026, the P&P indicated, The facility will identify residents at risk for pressure ulcers and provide care and services to promote the prevention of pressure ulcer development.1. Risk Identification and Assessment: .B. The Licensed Nurse will conduct a skin assessment for a resident upon admission, readmission, weekly, and as needed. Results of the weekly skin assessment will be documented in the medical record.During a review of facility's P&P titled, Medication Administration, dated 7/1/2016, and last reviewed on 1/26/2026, the P&P indicated, If the Attending Physician increases or changes a medication order, this is an automatic stop or discontinue order for the original order.XIX. Documentation.B. Recording will include the date, the time and the dosage of the medication or type of treatment.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice for one of four sampled residents (Resident 9) by failing to ensure nurses administer hydrocodone (medication used to treat severe and persistent pain) and morphine (a strong pain-relief medicine that can cause life-threatening breathing problems) for severe pain level as per physician order.These failures had the potential to result in Resident 9's sedation (state of calmness, relaxation, or sleepiness caused by certain drugs) that could lead to slow and shallow breathing.Findings:During a review of Resident 9?s admission Record, the admission Record indicated the facility admitted Resident 9 on 4/5/2023, with diagnoses that included generalized muscle weakness and unspecified (unconfirmed) polyarthritis (inflammation affecting five or more joints simultaneously. It causes joint pain, swelling, and stiffness). During a review of Resident 9's Order Review History Report, dated 6/4/2023, the Order Review History Report indicated the following orders:1. Tylenol (medication used to treat pain and fever) oral tablet 325 milligram (mg-metric unit of measurement, used for medication dosage and/or amount), give two tablets by mouth every four hours as needed for mild (pain level from 1 to 3 out of 10) pain or general discomfort.2. Acetaminophen (medication used to treat pain and fever) suppository (a medication designed to be inserted into the anus) 650 mg, insert one suppository rectally (giving a medication through the anus) every four hours as needed for mild pain or general discomfort if unable to tolerate by mouth.During a review of Resident 9's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 3/20/2026, the H&P indicated Resident 9 did not have the capacity to understand and make decisions.During a review of Resident 9's Minimum Data Set (MDS-a resident assessment tool), dated 4/1/2026, the MDS indicated Resident 9's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact.During a review of Resident 9's Order Review History Report, dated 4/18/2026, the Order Review History Report indicated hydrocodone-acetaminophen oral tablet 5-325 mg, give one tablet by mouth every four hours as needed for severe pain (pain level between seven to ten out of 10 pain) for one month.During a review of Resident 9's Order Review History Report, dated 4/21/2026, the Order Review History Report indicated morphine sulfate solution 20 mg/ milliliter (ml- a metric unit of volume equal to one-thousandth of a liter), give 0.25 ml by mouth every two hours as needed for severe pain.During a review of Resident 9's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 4/2026, the MAR indicated nurses administered morphine on the following dates and time:1. on 4/22/2026 at 6:57 p.m., with a pain level of 3/10.2. on 4/24/2026 at 3:33 a.m., with a pain level of 5/103. on 4/23/2026 at 8:47 p.m., with a pain level of 6/104. on 4/24/2026 at 6:50 a.m., with a pain level of 6/10.5. on 4/24/2026 at 6:38 p.m., with a pain level of 6/10. During a review of Resident 9's MAR, dated 4/2026, the MAR indicated the following:1. Nurses administered hydrocodone to Resident 9 who had a pain level of 0/10 (no pain) on 4/9/2026 at 6:52 p.m.2. Nurses administered hydrocodone to Resident 9 who had a pain level of 4/10 on the following dates and times: -4/3/2026, at 10:11 a.m. -4/9/2026, at 10:51 p.m. -4/10/2026, at 6:02 a.m. -4/10/2026, at 3:51 p.m. -4/11/2026, at 1 a.m. -4/11/2026, at 8:39 p.m. - 418/2026, at 6:27 a.m.3. Nurses administered hydrocodone to Resident 9 who had a pain level of 5/10 on the following dates and times: -4/5/2026, at 9 p.m. -4/6/2026, at 2:11 a.m. -4/7/2026, at 3:44 a.m. - 4/8/2026, at 8:30 p.m. -4/9/2026, at 5:48 a.m. -4/11/2026, at 6:37 a.m. -4/12/2026, at 10:41 a.m. -4/15/2026, at 9:30 p.m.4. Nurses administered hydrocodone to Resident 9 who had a pain level of 6/10 on: - 4/17/2026, at 9:55 a.m.During a concurrent interview and record review on 5/20/2026, at 11:29 a.m. with RN 1, Resident 9's Physician Order, dated 6/4/2023, 4/18/2026, 4/21/2026, and MAR, dated 4/2026, were reviewed. RN 1 stated severe pain is a pain level from 7 to 10. RN 1 stated a pain level of 0/10 means no pain and LVN 2 should have not administered hydrocodone to Resident 9 on 4/9/2026, at 6:52 p.m. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN 1 stated pain level of 4/10 to 6/10 were moderate pain and the nurses should have called and obtain an order from the physician for pain medication to address moderate pain since Resident 9 did not have any pain medication for moderate pain. RN 1 stated nurses administered pain medication not for Resident 9's pain level. RN 1 stated that giving stronger pain medication can cause dizziness and could cause poor appetite.During an interview on 5/21/2026, at 12:05 p.m., with the RMN, the RMN stated severe pain is from level 7 to 10 out of 10. The RMN stated LVN 2 should not administer hydrocodone which is for severe pain as per physician order if Resident 9 had 0/10 pain. The RMN stated nurses should have clarified the orders. The RMN stated nurses must follow the physicians order and administer pain medication according to Resident 9's pain level. The RMN stated that receiving stronger pain medication more than Resident 9's pain could cause sleepiness resulting in less food intake and might slow Resident 9's respiration.During a review of facility's policy and procedure (P&P) titled, Pain Management, dated 8/1/2024, and last reviewed on 1/26/2026, the P&P indicated, To ensure accurate assessment and management of the resident's pain. A Licensed Nurse will assess residents for pain on admission and routinely as indicated by the resident's health and functional status. Facility Staff is responsible for helping the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain.II. Pain ManagementA. The Licensed Nurse will administer pain medication as ordered and document all medication administered on the Medication Administration Record (MAR).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for three of five sampled residents (Residents 3, 5, and 6) by failing to:1. Ensure Licensed Vocational Nurse 4 (LVN 4) and LVN 5 follow physician order to hold (to temporarily pause or skip a dose as instructed by a healthcare professional) metoprolol (medication used to treat hypertension [HTN- high blood pressure]) for Resident 3's systolic blood pressure (sbp- the top or first number in a blood pressure reading. It measures the maximum pressure the blood exerts against the artery walls when the heart beats and pumps blood throughout the body) below 120-millimeters of mercury (mmHg-standard unit of measurement for pressure).2. Ensure LVN 6 follow physician order to hold amlodipine (medication used to treat HTN) and metoprolol for Resident 5's sbp below 110 mmHg.3. Ensure LVN 7 follow physician order to hold midodrine (medication used to treat low blood pressure) for Resident 6's sbp above 120 mmHg. These failures had the potential to result in medication errors and could result in Resident 3 and 5's hypotension (low blood pressure) and Resident 6's HTN.Findings:a. During a review of Resident 3?s admission Record, the admission Record indicated the facility admitted Resident 3 on 8/13/2025, with diagnoses that included essential HTN.During a review of Resident 3's Order Audit Report, dated 4/20/2026, the Order Audit Report indicated metoprolol tartrate tablet, given 12.5 milligram (mg-metric unit of measurement, used for medication dosage and/or amount) by mouth twice a day for HTN, hold for sbp less than 120 mmHg.During a review of Resident 3's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 4/21/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS-a resident assessment tool), dated 4/27/2026, the MDS indicated Resident 3's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired.During a review of Resident 3's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 5/2026, the MAR indicated the following:1. LVN 5 administered metoprolol on 5/7/2026, at 9 a.m., with a blood pressure of 115/75 mmHg.2. LVN 4 administered metoprolol on 5/1/2026, at 5 p.m. with a blood pressure of 119/76 mmHg.3. LVN 4 administered metoprolol on 5/2/2026, at 5 p.m., with a blood pressure of 115/69 mmHg. 4. LVN 4 administered metoprolol on 5/5/2026, at 5 p.m. with a blood pressure of 117/79 mmHg.During an interview on 5/19/2026, at 11:29 a.m., with LVN 5, LVN 5 stated he (LVN 5) should have held the metoprolol as per physician order. LVN 5 stated Resident 3 could possibly get dizzy and fall because blood pressure was low.During an interview on 5/20/2026, at 10:49 a.m., with LVN 4, LVN 4 stated usually the physician's parameter (set of specific clinical guidelines that dictate how a treatment or medication should be administered) was to hold blood pressure medication below 110 mmHg. LVN 4 stated the physician might have changed the order to hold metoprolol below 120 mmHg. LVN 4 stated she (LVN 4) had given the metoprolol because she (LVN 4) had documented it was given. LVN 4 stated she (LVN 4) should have checked the physician order first. LVN 4 stated Resident 3 could develop hypotension. During an interview on 5/20/2026, at 11:29 a.m., with Registered Nurse 1 (RN 1), RN 1 stated LVN 4 and LVN 5 should have read the physician order before medication administration. RN 1 stated that because blood pressure medication was administered to Resident 3, below the blood pressure parameter, Resident 3 could experience hypotension.During an interview on 5/21/2026, at 12:05 p.m., with the Risk Management Nurse (RMN), the RMN stated LVN 4 and LVN 5 should have validated the physician order and held the metoprolol if sbp is below 120 mmHg. The RMN stated Resident 3's blood pressure could drop and cause hypotension.b. During a review of Resident 5?s admission Record, the admission (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record indicated the facility admitted Resident 5 on 10/2/2018, with diagnoses that included congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 5's Order Review History Report, dated 10/9/2025, the Order Review History Report indicated the following order:1. metoprolol tartrate tablet 25 mg, give half a tablet via gastrostomy tube (g-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) in the morning and at bedtime, hold for sbp less than 110 mmHg.2. amlodipine besylate tablet five mg, give one tablet via g-tube daily for HTN, hold for sbp less than 110 mmHg.During a review of Resident 5's H&P, dated 10/10/2025, the H&P indicated Resident 5 did not have the capacity to understand and make decisions.During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognitive skills for daily decisions were severely impaired.During a review of Resident 5's MAR, dated 5/2026, the MAR indicated on 5/4/2026, at 9 a.m., LVN 6 administered amlodipine and metoprolol to Resident 5 who had a blood pressure of 97/54 mmHg.During a concurrent interview and record review on 5/20/2026, at 11:29 a.m., with RN 1, Resident 5's Physician Order, dated 10/9/2025, and MAR, dated 5/4/2026, were reviewed. RN 1 stated LVN 6 documented that she (LVN 6) administered amlodipine and metoprolol to Resident 5 on 5/4/2026, at 9 a.m., with a blood pressure of 97/54 mmHg. RN 1 stated Resident 5's blood pressure can drop and cause hypotension.During an interview on 5/21/2026, at 12:05 p.m., with the RMN, the RMN stated the physician ordered to hold the amlodipine and metoprolol if blood pressure is below 110 mmHg. The RMN stated LVN 6 should have held the medications to prevent hypotension.c. During a review of Resident 6?s admission Record, the admission Record indicated the facility admitted Resident 6 on 3/31/2025, with diagnoses that included unspecified hypotension and history of falling.During a review of Resident 6's Order Review History Report, dated 9/19/2025, the Order Review History Report indicated an order for midodrine hydrochloride tablet 10 mg, give one tablet by mouth three times a day for hypotension, hold for sbp greater than 120 mmHg.During a review of Resident 6's H&P, dated 9/22/2025, the H&P indicated Resident 6 had fluctuating capacity to understand and make decisions.During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decisions were moderately impaired.During a review of Resident 6's MAR, dated 5/2026, the MAR indicated on 5/10/2026, at 1 p.m., LVN 7 administered midodrine to Resident 6 at the following times:1. 9 a.m., with blood pressure of 122/62 mmHg.2. 1 p.m., with a blood pressure of 126/68 mmHg.During a concurrent interview and record review on 5/20/2026, at 11:29 a.m., with RN 1, Resident 6's Physician Order, dated 9/19/2025, and MAR, dated 5/10/2026, were reviewed. RN 1 stated LVN 7 should have followed the physician order and held the midodrine. RN 1 stated Resident 6 could have elevated blood pressure because physician order was not followed.During an interview on 5/21/2026, at 12:05 p.m., with the RMN, the RMN stated LVN 7 should have held the midodrine per physician order to prevent HTN.During a review of facility's policy and procedure (P&P) titled, Medication Administration, dated 7/1/2016, and last reviewed on 1/26/2026, the P&P indicated, To provide practice standards for safe administration of medications for residents in the Facility.I. Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner.VI. Tests and taking of vital signs, upon which administration of medications or treatments are conditioned, will be performed as required and the results recorded.VII. When administration of the drug is dependent upon vital signs or testing, the vital signs/testing will be completed prior to administration of the medication and recorded in the medical record (blood pressure, pulse, finger stick blood glucose monitoring).

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	05/21/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure safe provision of pharmaceutical services for four of nine sampled residents (Residents 4, 6, 10, and 11) during treatment cart storage observation by failing to:1. Ensure Resident 4's nystatin cream (medication used to treat skin infections caused by yeast) was labeled with an open date.2. Ensure Resident 6's Silver Silvadene cream (medication used to prevent, manage, and treat burn wound infections) was labeled with an open date.3. Ensure Resident 10's Santyl (medication used to clean dead, damaged tissue from severe burns and chronic skin ulcers [a small open sore or wound generally found in the stomach or on the skin]) was labeled with an open date.4. Ensure Resident 11's Dakins solution (diluted bleach used to kill germs without hurting a healing wound) was labeled with an open date.These failures had the potential to cause medication errors and could possibly lead to unsafe medication administration affecting Residents 4, 6, 10, and 11.Findings:During an interview on 5/15/2026, at 11:47 a.m., with Treatment Nurse (TN) 4, TN 4 stated the facilities treatment cart was not organized and medications had no written open dates.During a concurrent observation and interview on 5/19/2026, at 8:50 a.m., with TN 1, facility's treatment cart for station A was reviewed. TN 1 stated the following medications did not have an open date written on the medication. TN 1 stated each medication once opened should have a written open date.1. Resident 4's nystatin-triamcinolone cream.2. Resident 6's Silver Silvadene cream one percent (%)3. Resident 10's Santyl external ointment 250 unit per gram4. Resident 11's Dakins solution.During an interview on 5/20/2026, at 11:29 a.m. with Registered Nurse 1 (RN 1), RN 1 stated nurses should write the open date on the multidose medications when they open the medication so it can be discarded timely before the 30th day.During an interview on 5/21/2026, at 12:05 p.m., with the Risk management Nurse (RMN), the RMN stated it is important to write the open date on multidose medication to know when it should be discarded. The RMN stated it is the facility's policy to write the open date on the medication container.During a review of facility's policy and procedure (P&P), titled, Specific Medication Administration Procedures, dated 4/2008, and last reviewed on 1/26/2026, the P&P indicated, To administer medications in a safe and effective manner.E. Check expiration date on package/container. When opening a multi-dose container, place the date on the container.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate and complete medical record for three of nine sampled residents (Residents 3, 8, and 9) by failing to:1. Ensure accurate documentation of Resident 3's location of pressure ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence) on 5/8/2026.2. Ensure accurate documentation of Resident 8's location of pressure ulcer in the weekly Skin Checks on 4/23/2026, 4/30/2026, and 5/7/2026.3. Ensure accurate documentation of Resident 8's right heel deep tissue injury (DTI-purple or maroon localized area of discolored intact skin or bloodˆfilled blister due to damage of underlying soft tissue from pressure and/or shear) on 5/2026 Treatment Administration Record (TAR).4. Ensure accurate documentation of Resident 9's weekly Skin Check on 4/16/2026.These failures had the potential to cause confusion in the care and the medical records containing inaccurate documentation for Residents 3, 8, and 9.Findings:a. During a review of Resident 3?s admission Record, the admission Record indicated the facility admitted Resident 3 on 8/13/2025, with diagnoses that included vascular (having to do with the blood vessels and circulation) dementia (a progressive state of decline in mental abilities), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparesis (partial weakness, heaviness, or numbness on just one entire side of your body) following cerebral infarction (a critical medical emergency caused by a blocked or narrowed blood vessel in the brain).During a review of Resident 3's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 4/21/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS-a resident assessment tool), dated 4/27/2026, the MDS indicated Resident 3's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired.During a review of Resident 8's Change in Condition (CIC), dated 5/8/2026, the CIC indicated Resident 3 had unstageable pressure ulcer (a severe wound where the true depth and severity cannot be seen because it is completely obscured by dead tissue) to left inner knee and left buttocks. The CIC indicated Treatment Nurse 1 (TN 1) obtained an order of Santyl (medicine that removes dead tissue from wounds so they can start to heal) for unstageable pressure ulcer to left inner knee and hydrogel (medication used to promote wound healing, deliver medications and hydrate skin) for right buttocks excoriation (a scrape or scratch to the skin).During a concurrent interview and record review on 5/19/2026, at 10:26 a.m., with TN 1, Resident 3's CIC dated 5/8/2026, was reviewed. TN 1 stated Resident 3 had excoriation to right buttocks and not the left buttocks as indicated in the 5/8/2026 CIC. TN 1 stated she (TN 1) documented the wrong location of excoriation.During an interview on 5/20/2026, at 11:29 a.m., with Registered Nurse 1 (RN 1), RN 1 stated TN 1 made an incorrect documentation. RN 1 stated Resident 3 had excoriation on the right buttocks. RN 1 stated TN 1 should document accurately.During an interview on 5/21/2026, at 12:05 p.m., with the Risk Management Nurse (RMN), the RMN stated TN 1 made an inaccurate documentation in Resident 3's CIC on 5/8/2026. The RMN stated TN 1 should document accurately. The RMN stated inaccurate documentation of location of wound could result in inaccurate treatment provided.b. During a review of Resident 8?s admission Record, the admission Record indicated the facility admitted Resident 8 on 2/20/2026, with diagnoses that included stage three right heel pressure ulcer (full-thickness loss of skin. Dead and black tissue may be visible) and generalized weakness.During a review of Resident 8's H&P, dated 2/20/2026, the H&P indicated Resident 8 did not have the capacity to understand and make decisions.During a review of Resident 8's Care Plan, dated 2/25/2026, the Care Plan indicated stage three right heel pressure ulcerDuring a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8's cognitive skills for daily decisions were severely impaired. The MDS indicated (continued on next page)

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	555579	A. Building B. Wing	05/21/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 8 had one stage three pressure ulcer.During a review of Resident 8's Progress Notes, dated 4/19/2026, the Progress Notes indicated Resident 8 had stage three pressure ulcer to right heel.During a review of Resident 8's Skin Check, dated 4/23/2026, the Skin Check indicated TN 4, documented left heel stage three pressure ulcer.During a review of Resident 8's Skin Check, dated 4/30/2026, the Skin Check indicated TN 4 documented left heel stage three pressure ulcer.During a review of Resident 8's Skin Check, dated 5/7/2026, the Skin Check indicated TN 2 documented left heel stage three pressure ulcer.During an interview on 5/19/2026, at 10:42 a.m., with TN 1, TN 1 stated Resident 8 had no pressure ulcer to the left heel only in the right heel.During an interview on 5/19/2026, at 1:30 p.m., with TN 2, TN 2 stated Resident 8 had right heel pressure ulcer and not in left heel. TN 2 stated he (TN 2) should have documented accurately the correct location of stage three pressure ulcer.During an interview on 5/20/2026, at 11:29 a.m., with RN 1, RN 1 stated TN 2 documented the wrong site of pressure ulcer. RN 1 stated TN 2 should have documented pressure ulcer to right heel instead of the left heel.During an interview on 5/21/2026, at 12:05 p.m., with the RMN, the RMN stated TN 2 should assess Resident 8's skin weekly and document accurately in the Skin Check to prevent confusion in care.c. During a review of Resident 8's Progress Notes, dated 5/4/2026, the Progress Notes indicated the Wound Care Provider (WCP) assessed Resident 8 with unstageable pressure ulcer to upper mid back and DTI to right heel.During a review of Resident 8's Order Audit Report, dated 5/7/2026, the Order Audit Report indicated TN 2 obtained an order to clean right heel stage three pressure ulcer with normal saline (salt water) and paint with betadine (powerful, dark-brown liquid or ointment used to kill germs on the skin, clean minor cuts and scrapes, and prevent infections) daily.During a review of Resident 8's TAR, dated 5/2026, the TAR indicated daily treatment was provided to Resident 8's right heel stage three pressure ulcer with betadine.During a concurrent interview and record review on 5/19/2026, at 10:42 a.m., with TN 1, Resident 8's Progress Notes, dated 5/4/2026, and TAR dated 5/2026, were reviewed. TN 1 stated the WCP came on 5/4/2026 and assessed Resident 8 with right heel DTI. TN 1 stated TAR for right heel had a wrong documentation of the stage of pressure ulcer as it still indicated right heel stage three instead of DTI, but the treatment was already correct with betadine.During an interview on 5/20/2026, at 11:29 a.m., with RN 1, RN 1 stated the treatment record had incorrect pressure ulcer staging. RN 1 stated TAR should reflect the accurate stage of pressure ulcer. RN 1 stated TNs should have seen and corrected the stage of pressure ulcer since they (TNs) provide daily treatment to Resident 8.During an interview on 5/20/2026, at 12:05 p.m., with the RMN, the RMN stated the TAR should match the physician order. The RMN stated the TAR should have been updated to ensure accurate documentation.d. During a review of Resident 9?s admission Record, the admission Record indicated the facility admitted Resident 9 on 4/5/2023, with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and generalized muscle weakness.During a review of Resident 9's H&P, dated 3/20/2026, the H&P indicated Resident 9 did not have the capacity to understand and make decisions.During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9's cognitive skills for daily decisions were intact.During a review of Resident 9's Progress Notes, dated 4/10/2026 timed at 11:29 a.m., the Progress Notes indicated Resident 9 had right shin (front part of your lower leg, specifically the area between your knee and your ankle) fluid filled blisters (a small, fluid-filled bubble or pocket that forms just under the top layer of your skin).During a review of Resident 9's Progress Notes, dated 4/10/2026, timed at 11:38 a.m. the Progress Notes indicated Resident 9 had a change in condition of multiple ruptured blisters.During a review of Resident 9's Skin Check dated 4/16/2026, the Skin Check indicated left medical foot (near the second knuckle) scab and left medial foot (near the big toe knuckle) blister.During a concurrent interview and record review on 5/19/2026, at 11:04 a.m., with TN 1, Resident 9's, COC, dated 4/10/2026, and Skin Check dated 4/16/2026, were reviewed. TN 1 stated Resident 9 had a change in condition and had blisters on the right shin. TN 1 stated the right shin did not reflect in the 4/16/2026, Skin Check. TN 1 stated whoever the TN did not document accurately. (continued on next page)

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Ararat Nursing Facility	15099 Mission Hills Road Mission Hills, CA 91345

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	TN 1 stated it is important to conduct weekly skin check and document accurately.During an interview on 5/20/2026, at 11:29 a.m., with RN 1, RN 1 stated Resident 9 had ruptured blisters on both legs. RN 1 stated TNs did not make an accurate documentation of the skin assessment. RN 1 stated TNs should do a thorough skin assessment weekly and should make an accurate documentation of what was observed.During an interview on 5/21/2026, at 12:05 p.m. with the RMN, the RMN stated TNs should have assessed and documented accurately. The RMN stated documentation in residents medical record should be complete and accurate.During a review of facility's policy and procedure (P&P) titled, Wound Management, dated 11/1/2017, and last reviewed on 1/26/2026, the P&P indicated, Documentation will include: .i. Location of wound.During a review of facility's P&P, titled, Documentation-Nursing, dated 1/1/2016, and last reviewed on 1/26/2026, the P&P indicated, Nursing documentation will be concise, clear, pertinent, and accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its infection control measures for two of seven sampled residents (Residents 4 and 6) by failing to:1. Ensure Resident 4's oxygen tubing (flexible tubing that carries oxygen from an oxygen source to the user) was not touching the floor.2. Ensure Treatment Nurse 1 (TN 1) wore gloves when applying new foam dressing to Resident 4's stage two pressure injury (Partial-thickness loss of skin, presenting as a shallow open sore or wound).3. Ensure Certified Nursing Assistant 1 (CNA 1) wore gown when providing bed bath to Resident 6 who was on enhanced barrier precaution (EBP- an infection control method used in nursing homes to prevent the spread of hard-to-treat germs, like antibiotic-resistant bacteria).These failures had the potential to spread and expose other residents to infection.Findings:a. During a review of Resident 4?s admission Record, the admission Record indicated the facility admitted Resident 4 on 3/13/2026, with diagnoses that included unspecified (unconfirmed) respiratory failure (a condition in which the blood does not have enough oxygen or has too much carbon dioxide), unspecified dementia (a progressive state of decline in mental abilities) and generalized weakness.During a review of Resident 4's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 3/14/2026, the H&P indicated Resident 4 had the capacity to understand and make decisions.During a review of Resident 4's Minimum Data Set (MDS-a resident assessment tool), dated 4/22/2026, the MDS indicated Resident 4's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact.During a review of Resident 4's Order Recap Report, dated 5/6/2026, the Order Recap Report indicated oxygen at three liters per minute via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) continuously for shortness of breath.During an observation on 5/15/2026, at 1:46 p.m., inside Resident 4's room, Resident 4's oxygen tubing touching the floor.During a concurrent observation and interview on 5/15/2026, at 1:49 p.m., with Licensed Vocational Nurse 3 (LVN 3), at Resident 4's bedside, LVN 3 stated Resident 4's oxygen tubing was touching the floor. LVN 3 stated oxygen tubing should not touch the floor for infection control.During an interview on 5/19/2026, at 12:45 p.m., with the Infection Preventionist (IP), the IP stated oxygen tubing should not touch the floor because it could be contaminated (something is made dirty or unsafe) and cause a spread of infection.b. During a concurrent observation and interview on 5/19/2026, at 9:19 a.m., with Registered Nurse 1 (RN 1), RN 1 stated Resident 4 was on EBP.During an observation on 5/19/2026, at 9:20 a.m., with TN 1, at Resident 4's bedside, TN 1 was standing on Resident 4's right side while Registered Nurse 1 (RN 1) on the left side of Resident 4, assisting TN 1 with dressing change. Observed TN 1 cleanse Resident 4's stage two left buttocks pressure ulcer with saline (salt water) wet gauze, then TN 1 removed her (TN 1) gloves, used alcohol-based hand rub (often called hand sanitizer-is a liquid or gel used to quickly kill germs on your hands), don (put on) gloves, and dry wound with gauze. Observed TN 1 removed gloves, took a tongue depressor (a medical instrument made of wood), and applied zinc oxide (a medicated cream, ointment or paste that treats or prevents skin irritation like cuts, burns or diaper rash) to Resident 4's left buttocks pressure injury and applied a new foam dressing with no gloves.During an interview on 5/19/2026, at 12:45 p.m., with the IP, the IP stated TN 1 should have worn gloves when applying a dressing since Resident 4 was on EBP. The IP stated wearing gloves prevents the spread of infection like multidrug resistance organism (MDRO- refers to germs that have developed resistance to three or more classes of antibiotic [medication used to treat infection]).c. During a review of Resident 6?s admission Record, the admission Record indicated the facility admitted Resident 6 on 3/31/2025, with diagnoses that included chronic respiratory failure (a long-term condition that happens when your lungs cannot get enough oxygen into your blood) and urinary tract infection (UTI- an infection in the bladder/urinary tract) with urinary device.During a (continued on next page)

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	555579	A. Building B. Wing	05/21/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident 6's Order Review History Report, dated 9/19/2025, the Order Review History Report indicated urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) to gravity, drain every shift.During a review of Resident 6's H&P, dated 9/22/2025, the H&P indicated Resident 6 had fluctuating capacity to understand and make decisions.During a review of Resident 6's Order Review History Report, dated 4/20/2026, the Order Review History Report indicated to cleanse coccyx (tailbone) stage two pressure injury (partial-thickness loss of skin, presenting as a shallow open sore or wound) with normal saline, pat dry, apply nickel thick Santyl (medication used to remove damaged tissue from chronic skin ulcers and severely burned areas) ointment then cover with foam dressing.During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 6 had a urinary catheter.During an observation on 5/15/2026, at 1:37 p.m., outside of Resident 6's room, an EBP signage posted by the door and an isolation cart with gloves, gown and mask observed. Resident 6's door was open and curtain was pulled close.During an observation on 5/15/2026, at 1:38 p.m., inside Resident 6's room, Resident 6 laying in bed with urinary catheter hanging to the right side of the bed covered with a dignity bag. Observed CNA 1 standing on the left side of Resident 6 providing bed bath.During a concurrent observation and interview on 5/15/2026, at 1:39 p.m. with CNA 1 at Resident 6 bedside. CNA 1 stated she (CNA 1) was providing bed bath to Resident 6 who had a urinary catheter. CNA 1 stated she (CNA 1) did not wear a gown and should have worn a gown before providing bed bath.During a concurrent observation and interview on 5/15/2026, at 1:41 p.m., with Assistant Director of Staff Development 2 (ADSD 2), outside of Resident 6's room. ADSD 2 stated Resident 6 had an EBP signage posted by the door that should remind staff to wear personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) when providing care like bed bath. ADSD 2 went inside the room and stayed with Resident 6.During a concurrent observation and interview on 5/15/2026, at 1:43 p.m., with CNA 1 outside of Resident 6's room, CNA 1 came out of Resident 6 room without gloves. CNA 1 stated she (CNA 1) had forgotten to wear a gown before giving bed bath, CNA 1 stated she (CNA 1) had to wear a gown to protect Resident 6 from infection. Observed CNA 1 used ABHR, don gloves and gown and went back inside the room.During an interview on 5/15/2026, at 1:44 p.m. with ADSD 2, ADSD 2 stated CNA 1 did not wear a gown when providing bed bath to Resident 6 who was on EBP. ADSD 2 stated CNA 1 should have worn a gown for infection control.During an interview on 5/19/2026, at 12:45 p.m. with the IP, the IP stated CNA 1 should have worn a gown before entering the room of Residents 6 who was on EBP since she (CNA 1) knows she (CNA 1) will give a bed bath to Resident 6 and to prevent Resident 6 from MDRO.During a review of facility's policy and procedure (P&P) titled, Standard and Enhanced Precautions, dated 4/1/2024, and last reviewed on 1/26/2026, the P&P indicated, Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities that are associated with a high risk of MDRO colonization (means that bacteria, fungi, or viruses are living and multiplying on or in the body, but they are not causing any harm or illness) when contact precautions do not otherwise apply and/or transmission such as presence of indwelling devices (like urinary catheter.) and wounds or presence of unhealed pressure ulcers.B. Glovesi. Gloves (clean, non-sterile) are worn when direct contact with blood, body fluids, mucous membranes, non-intact skin, and other potentially infected material is anticipated.D. Gownsi. A gown is worn to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions or cause soiling of clothing.V. Enhanced Barrier PrecautionsB. For residents whom EBP are indicated, EBP should be used when performing the following high-contact resident care activities: .i. Dressing,ii. Bathing/showering.viii. Wound care: any skin opening requiring a dressing