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	07/18/2025

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the decision of the resident representative were given the same consideration as if the resident made the decision themselves for one of seven sampled residents (Resident 102) reviewed for accidents by failing to assess and implement Resident Representative (RR) 1's request for a least restrictive form of physical restraint (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for safety. This deficient practice had denied the right of the resident representative to advocate for the resident who was deemed incompetent to make medical decisions. Findings:During a review of Resident 102's admission Record, the admission Record indicated the facility admitted the resident on 5/6/2021, and readmitted the resident on 4/19/2023, with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), age-related osteoporosis (is a condition where bones become thin, weak, and brittle with age, making them more likely to break), and history of falling. During a review of Resident 102's History and Physical (H&P), dated 4/1/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 102's Minimum Data Set (MDS - a resident assessment tool), dated 6/11/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had impaired vision. The MDS indicated the resident had severe cognitive impairment (a significant decline in a person's ability to think, learn, remember, concentrate, or make decisions), upper and lower extremity impairment, and uses a walker and wheelchair to mobilize self. The MDS indicated that the resident required substantial to partial assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 102's Fall Risk Assessments, dated 3/13/2025, 6/11/2025, and 7/8/2025 status post-fall, the Fall Risk Assessments indicated the resident was high risk for falls. During a review of Resident 102's Progress Notes, dated 7/4/2025, the Progress Notes indicated that at 3:25 a.m., Certified Nursing Assistant (CNA) 6 observed Resident 102 getting out of bed unassisted, the resident lost balance and fell on the floor. Resident 102 stated she wanted to go to the bathroom. Resident 102 sustained 4 centimeters (cm - a unit of measurement) by (X) 1 cm skin tear on the left elbow. The physician and family member notified of resident transfer to general acute care hospital (GACH 1). During a review of Resident 102's Progress Notes, dated 7/7/2025, the Progress Notes indicated the resident was readmitted to the facility from GACH 1 status post (s/p) fall with fractures (a broken bone). The resident was observed with a skin discoloration on the right antecubital fossa (the area in front of your elbow, also known as the elbow pit) 2 cm X 0.5 cm, skin discoloration on the right arm, 2 cm X 2 cm skin discoloration on left forearm 3 cm X 0.5 cm. Resident 102 had a brace on her left wrist. During a review of Resident 102's Radiology Report, dated 7/11/2025, the Radiology Report of left wrist, 3 views, indicated findings of acutely complex impacted fracture (occurs when the broken ends of the bone are jammed together by the force of the injury) of distal radius (the larger forearm bone is broken near the wrist) with dorsal angulation (a bone is bent or angled towards the back). During a review of Resident 102's Post Fall Assessment/Intervention, dated 7/4/2025, the Post Fall Assessment/Intervention indicated the resident was observed attempting to get out of bed unassisted, lost balance and fell on the floor. The resident required supervision/touching assistance and determined the cause or pattern of the resident's fall was unsteady gait (the way a person walks), poor judgment, and dementia (a progressive state of decline in mental abilities). During a review of Resident 102's Interdisciplinary Team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of their clients) Notes, dated 7/11/2025, the IDT Notes indicated RR 1 had requested to have something at night to keep her in bed like a tie, but the facility told her that it was a physical restraint. During a review of Resident 102's Care Plan (CP) Report titled Resident had a witnessed fall incident, initiated on 7/4/2025, the CP indicated an intervention for 11-7 shift staff to check on resident from 2 a.m. to 4 a.m. to see if resident is asleep or needs assistance in ADLs. During an interview on 7/17/2025 at 8:45 a.m. with RR 1, on the phone, RR 1 stated her mom can wake up in the middle of the night confused and she does not remember anything, she can walk by herself and is not calling for assistance. RR 1 stated that she is [AGE] years old, and she is barely walking, and her mind is not working as it used to. RR 1 stated it is very hard for caregivers to monitor her. RR 1 stated she suggested to the facility to use some

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three of five sampled residents (Resident 2, 19, 27) reviewed under unnecessary medication, were afforded the right to informed consent for the use of psychotherapeutic medications (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) by failing to: 1. Ensure an informed consent was obtained from Resident 2 or Resident 2's responsible party (RP) prior to starting doxepin (an antidepressant [against depression] medication classified as a psychotherapeutic drug {a drug that changes brain function and results in alterations in perception, mood, consciousness or behavior} used to treat depression) ensuring that the risk and benefit of doxepin were explained to the resident or RP, and for a new dose of clonazepam (a psychotropic medication used to treat anxiety) and for the use of quetiapine (an antipsychotic medication used to treat serious mental health conditions such as psychosis]) after six (6) months. 2. Ensure informed consent was obtained from the resident and/or RP for Resident 19, prior to starting Ativan (a type of medication used to treat anxiety disorders [a mental health condition where excessive fear and worry interfere with daily life, causing significant distress], sleeplessness, nausea, and agitation) ensuring that the risk and benefit of Ativan were explained to the resident and/or RP. 3. Ensure informed consent was obtained from the resident and/or RP for the continued use of Remeron (a type of medication used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest] every six (6) months. These deficient practices violated Resident 2s', 19s' and 27s' right to be fully informed, to consent and to make decisions regarding the use of their psychotherapeutic medications. Findings: During a review of Resident 2's admission Record, the admission Record dated 7/17/2025, the record indicated Resident 2 was originally admitted to the facility on [DATE] with diagnosis including psychosis, depression, anxiety, insomnia (difficulty sleeping) and dementia (a group of conditions that cause a decline in memory, thinking, language, and judgment). During a review of Resident 2's History and Physical report, completed on 7/31/2024, the History and Physical Report indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of the Minimum Data Set ([MDS - a resident assessment tool]) dated April 15, 2025, the MDS indicated Resident 2 had moderately impaired cognition for daily decision making, had no symptoms of feeling down, was depressed or hopeless, and was not marked for having trouble falling asleep, and was taking antipsychotic, antianxiety, antidepressant medications. During a review of Resident 2's Medication Administration Record ([MAR] - a record of mediations administered to residents) on 7/17/2025, July 2025, the MAR indicated Resident 2 was prescribed the following: 1.Administer clonazepam 1 mg one (1) tablet orally every 24 hours as needed for anxiety manifested by constantly getting out of bed at night, starting 5/8/2025 until 7/10/2025. 2. Administer clonazepam 0.5 mg one (1) tablet orally at bedtime for anxiety for 14 days manifested by impulsive behavior/agitation, at 9 p.m. starting 7/11/2025. 3.Administer doxepin 6 mg one (1) tablet orally in the evening for depression manifested by insomnia, at 5 p.m. starting 7/30/2024. 4.Administer quetiapine 50 mg two (2) tablets orally at bedtime for psychosis manifested by hallucination/delusion (seeing/talking to people not present), at 9 p.m. starting 7/30/2024. During a further review of the same MAR for July 2025, the MAR indicated Resident 2 was administered the following: 1.Clonazepam 0.5 mg one (1) tablet orally at 9 p.m. for anxiety for 14 days manifested by impulsive behavior/agitation, between 7/11/2025 and 7/16/2025 2.Doxepin 6 mg one (1) tablet orally at 5 p.m. for depression manifested by insomnia, between 7/1/2025 and 7/16/2025. 3.Quetiapine 50 mg two (2) tablets orally at 9 p.m. for psychosis manifested by hallucination/delusion (seeing/talking to people not present), between 7/1/2025 and 7/16/2025. During a review of Resident 2's clinical record on 7/17/2025, the clinical record lacked documentation for the following: 1.Obtaining informed consent for the updated clonazepam order to 0.5 mg at bedtime for anxiety for 14 days manifested by impulsive behavior/agitation, starting 7/11/2025. 2.Obtaining informed consent for doxepin 6 mg in the evening for depression manifested by insomnia, starting 7/30/2024. 3.Providing written notice to the resident or RP for quetiapine 50 mg two (2) tablets at bedtime for psychosis manifested by hallucination/delusion (seeing/talking to people not present), beyond six (6) months after the last signed consent on 11/29/2024. b)During a review of Resident 19's admission Record, the admission Record indicated the facility admitted the resident on 2/24/2021 with diagnoses including Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) within reach of the resident for three of the three sampled residents (Residents 125, 113 and 74) reviewed under the area of accommodation. The deficient practice had the potential to result in the residents being unable to summon health care workers for help as needed. Findings:1. During a review of Resident 125’s admission Record, the admission Record indicated the facility admitted the resident on 10/2/2018, and readmitted the resident on 8/14/2022, with diagnoses including age-related osteoporosis (a condition where bones become weak and fragile over time, primarily due to the natural aging process), history of traumatic fracture (a broken bone that happens because of a sudden, strong force or impact), and history of falling. During a review of Resident 125’s History and Physical (H&P), dated 8/20/2024, the H&P indicated the resident had fluctuating capacity to understand and make decisions due to chronic delirium (a serious disturbance in a person's mental abilities that results in a decreased awareness of one's environment and confused thinking). During a review of Resident 125’s Fall Risk Assessment, dated 5/25/2025, the Fall Risk Assessment indicated the resident was at a high risk for falls. During a review of Resident 125’s Minimum Data Set (MDS, a resident assessment tool), dated 5/28/2025, the MDS indicated the resident had the ability to make self-understood and to understand others and had highly impaired vision. The MDS indicated the resident had moderate cognitive impairment (a noticeable decline in thinking skills that affects daily life), upper and lower extremity impairment, and uses a wheelchair to mobilize. The MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 125’s Care Plan (CP) Report titled “Antipsychotic (medications used to treat conditions involving psychosis) drug therapy (Seroquel): At Risk for toxicity/At Risk for Fall, ” initiated on 8/8/2023, the CP indicated an intervention to keep call light within easy reach and answer promptly. During a concurrent observation and interview on 7/14/2025, at 1:11 p.m., with Certified Nursing Assistant (CNA) 9, while inside Resident 125’s room, Resident 125 was observed sitting in a wheelchair on the left side of the bed with the resident’s feet resting on top of the bed and the call light was placed on the foot part of the bed. CNA 9 stated the resident’s call light should be near the resident. CNA 9 stated the resident cannot reach the call light because it is not close to her and the resident can fall while reaching for it. During an interview on 7/18/2025, at 10 a.m., with Registered Nurse (RN) 4, RN 4 stated the call light of Resident 125 should always be within the reach of the residents when they are in bed or on a chair. RN 4 stated the staff should have placed the call light within the reach of the resident while they are sitting in the wheelchair and answer promptly when the call light goes off to prevent falls or other injuries. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/2025, at 1:39 p.m., with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the DON stated the call light should be within reach of Resident 125 and the call lights should be answered right away to prevent falls. During a review of the facility's recent policy and procedure (P&P) titled Communication- Call System, last reviewed on 4/28/2025, the P&P indicated to provide a mechanism for residents to promptly communicate with nursing staff. I. The Facility will provide a call system to enable residents to alert the nursing staff from their beds and toileting/bathing facilities. A. The call system should be accessible to a resident lying on the floor in toileting and bathing facilities. Procedure II. Call cords will be placed within the resident's reach in the resident's room. 2. During a review of Resident 113’s admission Record, the admission Record indicated the facility admitted the resident on 7/11/2022, with diagnoses including mild cognitive impairment (a condition where people experience more memory or thinking problems than other people their age, but it's not severe enough to interfere with their daily lives or be considered dementia), fracture (a broken or cracked bone) of left shoulder girdle, and age-related osteoporosis. During a review of Resident 113’s CP Report titled “High risk for falls due to fall risk assessment score,” initiated on 7/25/2022, the CP included an intervention to keep the call light within easy reach and answer promptly. During a review of Resident 113’s H&P, dated 7/24/2024, the H&P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 113’s Fall Risk Assessment, dated 5/8/2025, the Fall Risk Assessment indicated the resident was high risk for fall. During a review of Resident 113’s MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and to understand others and had moderate cognitive impairment. The MDS indicated Resident 113 had upper extremity impairment and used a walker and wheelchair to mobilize. The MDS indicated the residents were dependent on needing supervision with mobility and ADLs. The MDS indicated the resident had a fall without injury while a resident at the facility. During a concurrent observation and interview on 7/14/2025, at 1:57 p.m., with CNA 8, while inside Resident 113’s room, Resident 113 was observed in a wheelchair, at the left side of the bed, with the resident’s feet resting on top of the bed and the call light was placed on the foot part of the bed. CNA 8 stated the resident’s call light should be near the resident. CNA 8 stated the resident could not reach the call light because it is not close to her and she could fall while reaching it. CNA 8 stated the resident goes to the bathroom by herself. CNA 8 stated the resident was not a fall risk. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/2025, at 10 a.m., with RN 4, RN 4 stated the call light of Resident 113 should always be within the reach of the resident when they are in bed or on a chair. RN 4 stated the staff should have placed the call light within the reach of the resident while the resident was sitting in a wheelchair and answer promptly when the call light goes off to prevent falls or other injuries. During an interview on 7/18/2025, at 1:39 p.m., with the DON and the ADON, the DON stated the call light should be within reach of Resident 113 and the call lights should be answered right away to prevent falls. During a review of the facility's recent P&P titled Communication- Call System, last reviewed on 4/28/2025, the P&P indicated to provide a mechanism for residents to promptly communicate with nursing staff. I. The Facility will provide a call system to enable residents to alert the nursing staff from their beds and toileting/bathing facilities. A. The call system should be accessible to a resident lying on the floor in toileting and bathing facilities. Procedure II. Call cords will be placed within the resident's reach in the resident's room. 3. During a review of Resident 74’s admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted the resident on 4/27/2023 and readmitted in the facility on 7/26/2024, with diagnoses including Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and functional quadriplegia (complete inability to move due to severe disability or frailty [body’s inability ability to cope with minor illnesses] without physical injury). During a review of Resident 74’s fall risk assessments dated 3/4/2025 and 6/2/2025, the fall risk assessments indicated Resident 74 was at a high risk for falls. During a review of Resident 74’s History and Physical (H&P) dated 4/24/2025, the H&P indicated Resident 74 did not have the capacity to understand and make decisions. During a review of Resident 74’s Minimum Data Set (MDS, a resident assessment tool), dated 6/1/2025, the MDS indicated Resident 74 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) but was able to understand and make her needs known. The MDS further indicated Resident 74 required supervision or touching assistance with eating; substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 74’s care plan (CP) on potential for falls initiated on 4/17/2024 and last revised on 4/3/2025, the CP indicated to keep the resident's most frequently used personal items within easy reach and to keep call light within easy reach and answer promptly as a few of the interventions to minimize potential for fall or injury. During a concurrent observation and interview on 7/14/2025 at 12:59 p.m. while inside Resident 74’s room with Certified Nursing Assistant (CNA) 3 in the presence of Licensed Vocational Nurse (LVN) 8, Resident 74 lay in bed awake, verbally responsive with the call light placed at the uppermost edge of the bed on the right side. CNA 3 stated the staff should ensure all residents’ call lights are placed within reach prior to leaving the room so the residents can call for assistance when needed. CNA 3 stated she forgot to ensure the call light was within Resident 74’s reach after she removed the resident’s lunch tray. CNA 3 stated she should have ensured Resident 74’s call light was within reach prior to leaving the room so the resident can call for assistance when needed, which placed Resident 74 at risk for a delay in meeting the resident’s needs. During an interview on 07/18/2025 at 10 AM with Registered Nurse (RN) 4, RN 4 stated the call light should be within the reach of the residents when they are in bed or on a chair. RN 4 stated the staff should ensure the residents’ call lights are within reach prior to leaving the room. RN 4 stated Resident 74’s call light should have been placed within the resident’s reach as Resident 74 had limitations with her upper extremities and would be unable to call for assistance which may lead to a delay in meeting the resident’s needs. During a review of the facility's recent policy and procedure (P&P) titled “Call Light,” last reviewed on 4/8/2025, the P&P indicated: - All residents shall have immediate access to functioning call light at all times, ensuring they can easily signal for assistance whenever needed. -The call light must be within the resident’s reach at all times, including when in bed, in a chair, or in the bathroom. During a review of the facility’s P&P titled, Communication- Call System, last reviewed on 4/28/2025, the P&P indicated: -The Facility will provide a call system to enable residents to alert the nursing staff from their beds and toileting/bathing facilities. -The call system should be accessible to a resident lying on the floor in toileting and bathing facilities. -Call cords will be placed within the resident's reach in the resident's room.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based an observation, interview, and record review, the facility failed to ensure that nine of nine residents (Residents 59, 73, 116, 119, 123, 131, 135, 150 and 232) who attended the Resident Council Meeting (gathering of residents, typically in a long-term care or public housing setting, where they discuss issues, concerns, and suggestions related to their living environment and quality of life) on 7/15/2025, were aware of the availability and location of the facility's latest survey results. This failure had the potential for the residents and their legal representatives not to be fully informed of the facility's deficient practices and how they were corrected. Findings:During the Resident Council Meeting on 7/15/2025 at 11:03 a.m., attended by nine residents (Residents 59, 73, 116, 119, 123, 131, 135, 150 and 232), in the presence of two Activity Staff (AC 1 and AC 2), Residents 116 stated they were not aware of the availability and location of the survey results and how the facility corrected the deficiencies that were identified in the past survey. During a concurrent observation and interview on 7/15/2025 at 11:03 a.m., with AC 2, inside the classroom, AC 2 translated the question into the language used by the residents and AC 2 stated all nine residents (Residents 59, 73, 116, 119, 123, 131, 135, 150 and 232) stated they were not sure where to find the survey result. During a concurrent observation, interview, and record review on 7/15/2025 at 11:29 a.m. with the Administrator (ADM), in the facility's hallway beside the consumer board, observed the survey result binder hooked on the wall. The ADM stated the survey result binder did not contain the latest (2024) survey result. During an observation on 7/16/2025 at 9:27 a.m. in the hallway beside the consumer board, the survey results binder was missing. During a concurrent interview and record review on 7/16/2025 at 9:29 a.m. with the ADM, the ADM stated the survey results binder was in his (ADM) office being updated. The ADM brought the survey result binder and showed the latest recertification survey result was attached. The ADM stated the survey result binder did not contain the plan of correction for the latest survey result. The ADM stated his (ADM) staff did not follow his (ADM) instructions. During an interview on 7/16/2025 at 2:55 p.m. with the Assistant Director of Nursing (ADON), the ADON stated the purpose of the survey result binder was to inform the public that the facility had corrected the deficiencies or issues found during the latest survey. The ADON stated the survey result should be accessible to residents without asking any staff. During an interview on 7/16/2025 at 4 p.m. with the Director of Nursing (DON), the DON stated the survey results informs the residents and families of what's going on in the facility. The DON stated the survey binder contains the latest survey results and what the facility did to correct it. The DON stated the survey result binder should be accessible to residents, families, and staff. During a review of facility's policy and procedure (P&P) titled, Compliance with Laws and Professional Standards, dated 10/1/2017 and last reviewed on 4/28/2025, the P&P indicated, The Facility will post in place readily accessible to residents, family members, and legal representatives of residents, the results of the most recent survey of the Facility.A. Readily Accessible means that the individual(s) wishing to examine the most recent survey results should not ask to see them (staff) (example given, posted on an accessible wall).

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to notify the primary physician and responsible party of a significant change in condition (major decline or improvement in a resident's status that will not resolve itself without intervention) for one of six sampled residents (Resident 21) reviewed under the Nutrition care area by failing to notify the physician and family regarding significant weight loss per the facility policy and procedure (P&P) when the resident had a weight loss of greater than 5 pounds (lbs. - a unit of measurement for mass) in 30 days. This failure had the potential to result in a delay in care and services and a further decline of Resident 21. Findings:During a review of Resident 21's admission Record (AR), the AR indicated the facility originally admitted the resident on 1/18/2024 and most recently admitted the resident on 11/9/2024 with diagnoses that included metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), iron deficiency anemia (a condition in which blood lacks adequate healthy red blood cells), carcinoma in situ of vulva (abnormal cells are found on the surface of the vulvar [external female genitals] skin), malignant neoplasm (cancer - disease in which abnormal cells divide uncontrollably and destroy body tissue) of unspecified site of female breast, dysphagia (difficulty swallowing), and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 21's History and Physical (H&P), dated 4/11/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 21's Minimum Data Set (MDS - resident assessment tool), dated 5/5/2025, the MDS indicated the resident usually was able to understand others and usually was able to make herself understood. The MDS further indicated that the resident was dependent on staff for eating, toileting, bathing, dressing, oral and personal hygiene, and mobility. During a review of Resident 21's Order Review History Report, the Order Review History Report indicated the following physician's orders:-Fortified, no salt added diet pureed texture, regular consistency liquids, three times a day, dated 11/9/2024. During a review of Resident 21's Weights and Vitals Summary report, the Weights and Vitals Summary report indicated the following:-On 6/16/2025 at 9:48 a.m., Resident 21 weighed 102 lbs. while sitting.-On 7/14/2025 at 9:32 a.m., Resident 21 weighed 92 lbs. while sitting.--A 10 lb. weight loss of 9. 8 percent (% - a measurement) of previous comparison weight, over 30 days. During a review of Resident 21's Care Plan (CP) regarding the resident's history of malignant neoplasm of the right breast and carcinoma in situ of vulva, initiated 1/19/2025, the CP indicated the resident was at risk for weight loss. The CP indicated an intervention to report to the physician any weight loss. During a concurrent observation and interview on 7/15/2025 at 1:11 p.m. with Resident 21 and Resident 21's Family Member (FM) 1, observed FM 1 sitting at a table next to Resident 21. Resident 21 had a lunch tray placed in front of the resident containing pureed food. Resident 21 did not eat. FM 1 stated Resident 21 was not eating. FM 1 stated FM 1 thought Resident 21 did not like the texture of the food. During an interview on 7/17/2025 at 9:30 a.m. with Treatment Nurse (TN) 2, TN 2 stated residents are weighed monthly by the restorative nurse aides (RNA) and if there is a significant change in the resident's weight, the weight is reported to the charge nurse because it is considered a COC. TN 2 stated 10 lbs. weight loss is a significant change from the resident's baseline weight and is considered a COC. During a concurrent interview and record review on 7/17/2025 at 10:06 a.m. with Licensed Vocational Nurse (LVN) 6, Resident 21's Weight Monitoring form for 2024 and 2025 were reviewed. LVN 6 stated on 7/14/2025, the RNA told LVN 6 that Resident 21 had a bit of weight loss. LVN 6 stated LVN 6 did not follow up to review Resident 21's weight loss. LVN 6 reviewed the Weight Monitoring form and stated Resident 21 had lost 10 lbs. in one month. LVN 6 stated if a resident loses too much weight the physician should be notified. LVN 6 stated on 7/14/2025 nobody told LVN 6 the Resident had gone from 102 lbs. to 92 lbs. During a concurrent interview and record review on 7/17/2025 at 10:17 a. m. with Registered Nurse (RN) 2, Resident 21's Weights and Vitals form for 6/2025 and 7/2025 and Progress Notes for 7/2025 were reviewed. RN 2 stated Resident 21's weight loss of 10 lbs. in one month was a big weight loss and is concerning. RN 2 stated the family and physician should have been immediately notified on 7/14/2025. RN 2 stated there was no documentation to indicate the family and physician were notified of Resident 21's COC. RN 2 stated when a COC for weight loss in Resident 21 was not reported, it could potentially result in abnormal vital signs (measurements of the body's most basic functions including temperature, heart rate, respiratory rate, and blood pressure), skin issues, or a failure to thrive (an inability to sustain weight due to poor nutrition). During a concurrent interview and record review on 7/17/2025 at 11:09 a.m. with the Assistant Director of Nursing (ADON), Resident 21's Weights and Vitals form for 6/2025 and

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a safe, comfortable, and homelike environment for one (1) of two (2) sampled residents (Resident 27) reviewed under the environmental task by failing to ensure Resident 27's floor mat (a cushioned floor pad designed to help prevent injury should a person fall) was free from rips and disrepair. This deficient practice had the potential to negatively affect the residents' quality of life. Additionally, the facility failed to honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely for one of two sampled residents (Resident 187) reviewed under environment facility task by failing to ensure the resident's floor/fall mat (a cushioned floor pad designed to help prevent injury should a person fall) did not have any peeling covers. The deficient practice violated the residents' right to a safe, clean, comfortable and homelike environment. Findings:a). During a review of Resident 27’s admission Record, the admission Record indicated the facility admitted the resident on 8/1/2023 with diagnoses including Alzheimer’s Disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 27’s History and Physical (H&P), dated 8/16/2024, the H&P indicated Resident 27 did not have the capacity to understand and make decisions. During a review of Resident 27’s Order Summary Report, the Order Summary Report indicated a physician’s order dated 12/4/2024 that Resident 27 may have a floor mat next to the bed to prevent injuries every shift. During a review of Resident 27’s care plan (CP) risk for falls initiated on 7/25/2024 and last revised on 1/24/2025, the CP indicated to keep the environment free of hazards and floor mats next to the bed as a few of the interventions to minimize the potential for falls or injury. During a review of Resident 27’s Minimum Data Set (MDS-a resident assessment tool), dated 4/1/2025, the MDS indicated Resident 27 had minimal difficulty hearing, sometimes had the ability to make self-understood and understand others. The MDS indicated Resident 27 required substantial/maximal to total assistance from staff with all activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview on 7/14/2025, at 12:31 p.m. while inside Resident 27’s room with Licensed Vocational Nurse (LVN) 8. LVN 8 stated Resident 27’s floor mat with the right lower edges was peeling off and in disrepair. LVN 8 stated the floor mats should be replaced if the edges are peeling off or in disrepair, as it is not very homelike for Resident 27 and can affect her quality of life. LVN 8 stated the maintenance department should have been notified about the peeling fall mat cover edges and should be replaced. During an interview on 7/18/2025, at 10:15 a.m. with Registered Nurse (RN) 4, RN 4 stated the charge nurses/Certified Nursing Assistants (CNAs) are required to check the integrity of the floor mats to ensure that they are not damaged or in disrepair. RN 4 stated it was not appropriate to have floor mats with peeling covers in the resident’s room because it can cause a fall, and it is not homelike to see the edges of the floor mats peeling off in the resident’s room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/2025, at 1:39 p.m., with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the DON stated Resident 27’s floor mat should be free of wear and tear, and the mat should not have peeling covers on the edges as it compromises the integrity of the mat to prevent falls with injury. The DON also stated it is not homelike to see peeling covers on the floor mats of the residents. During a review of the facility's recent policy and procedure (P&P) titled Resident Rights- Personal Property, last reviewed on 4/28/2025, the P&P indicated to ensure the quality of life of all residents by allowing residents to create a home-like environment. During a review of the undated facility-provided Floor Mat 1 Manufacturer’s Specification, the Manufacturer’s Specification indicated when moving equipment across the mat ensure that the wheels are not locked as “dragging wheels” may damage the mat. Avoid sharp materials from contacting the mat. Never leave heavy materials on the mat for an extended amount of time because they may cause permanent indentation. b). During a review of Resident 187’s admission Record, the admission Record indicated the facility admitted the resident on 10/13/2023, with diagnoses including a history of falling, abnormalities of gait (how a person walks) and mobility, and age-related osteoporosis (a common condition that affects older adults, making their bones weak and fragile). During a review of Resident 187’s Care Plan (CP) Report titled “Psychosocial: Home like environment,” initiated on 10/20/2023, the CP indicated a goal of the facility will ensure resident’s room is a home like environment through 9/10/2025. During a review of Resident 187’s Minimum Data Set (MDS, a resident assessment tool), dated 6/11/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had impaired vision. The MDS indicated the resident had moderately impaired cognition (a stage between normal aging and dementia [a progressive state of decline in mental abilities] where individuals experience noticeable cognitive decline but can still manage most of their daily activities, though they may need some assistance), upper extremity, and uses a walker and a wheelchair to mobilize. The MDS indicated the resident required substantial supervision assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident had a fall with a major injury while a resident at the facility. During a review of Resident 187’s Fall Risk Assessment, dated 6/11/2025, the Fall Risk Assessment indicated the resident was high risk for falls. During a review of Resident 187’s History and Physical (H&P), dated 7/12/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a concurrent observation and interview on 7/14/2025, at 2:33 p.m. with the Director of Staff Development (DSD), while inside Resident 187’s room, Resident 187’s fall mat with had peeling covers at the edges. The DSD stated the fall mat should be replaced because the peeling covers had compromised the ability of the fall mat to reduce the impact of the fall if a resident lands on them. The DSD stated the peeling fall mat cover edges does not look homelike for a resident and should be replaced. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/18/2025, at 10 a.m., with Registered Nurse (RN) 4, RN 4 stated the charge nurses/Certified Nursing Assistants (CNAs) should be checking the integrity of the floor mats. The picture of the floor mat with peeling covers was reviewed with RN 4, RN 4 stated it was not appropriate to have floor mats with peeling covers in the resident’s room because it can cause a fall, it is not homelike to see peeling covers of the fall mat in the resident’s room. During an interview on 7/18/2025, at 1:39 p.m., with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the DON stated Resident 187’s floor mat should be free of wear and tear, the mat should not have peeling covers on the edges as it compromises the integrity of the mat to prevent falls with injury. The DON also stated it is not homelike to see peeling covers on the fall mats of the residents. During a review of the facility's most recent policy and procedure (P&P) titled Resident Rights- Personal Property, last reviewed on 4/28/2025, the P&P indicated to ensure the quality of life of all residents by allowing residents to create a home-like environment. During a review of the undated facility-provided Floor Mat 1 Manufacturer’s Specification, the Manufacturer’s Specification indicated when moving equipment across the mat ensure that the wheels are not locked as “dragging wheels” may damage the mat. Avoid sharp materials from contacting the mat. Never leave heavy materials on the mat for an extended amount of time because they may cause permanent indentation.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of three sampled residents (Resident 224) when on 6/28/2025 at 2:45 p.m., Certified Nursing Assistant 11 (CNA 11) witnessed Resident 45 approached Resident 224 and hit Resident 224 on the head and right lower extremity (RLE - right side of the lower part of the human body) with a single point cane (a mobility aid with a single tip that provides basic support and balance assistance for individuals with minor mobility issues). This deficient practice resulted in Resident 224 being subjected to physical abuse by Resident 45 while under the care of the facility. On 6/28/2025, Resident 224 sustained bruising (discoloration of the skin caused by blood pooling beneath the surface) and swelling on the RLE, redness on top of the head, and pain level of two (mild pain) out of 10 on the numeric pain rating scale (a pain assessment tool that uses a scale ranging from zero [0 - no pain] to 10 [worst pain imaginable], to quantify pain intensity). Resident 224 complained of mild headache on 6/28/2025 at 3:15 p.m. and Tylenol (a brand of medication used to treat mild to moderate aches and pains) 325 milligrams (mg - unit of measurement) two (2) tablets were administered to Resident 224. Findings: a. During a review of Resident 224's admission Record, undated, the admission Record indicated the facility originally admitted Resident 224 on 3/23/2022 and readmitted in the facility on 5/12/2024 with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 224's Order Summary Report dated 5/12/2024, the Order Summary Report indicated a physician's order for Tylenol oral tablet 325 mg, give two tablets by mouth every four hours as needed for mild pain or general discomfort not to exceed three (3) grams (gm - a unit of measurement) per 24 hours. During a review of Resident 224's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 5/1/2025, the H&P indicated Resident 224 did not have the capacity to understand and make decisions. During a review of Resident 224's Minimum Data Set (MDS - a resident assessment tool), dated 4/30/2025, the MDS indicated Resident 224 had severely impaired cognition (significant decline in a resident's mental abilities that profoundly impacts their daily life and independence), and usually had the ability to make self understood and understand others. The MDS indicated Resident 224 required partial or moderate assistance (helper does less than half of the effort) with eating and was totally dependent (helper does all of the effort) on staff with all other activities of daily living (ADLs - routine tasks or activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 224's Change of Condition (COC -major decline or improvement in a resident's status that will not resolve without intervention) form, dated 6/28/2025, timed at 5 p.m., the COC form indicated on 6/28/2025 at 2:45 p. m., Resident 224 was in the hallway (across Room A) sitting in the wheelchair and was yelling. The COC indicated that CNA 11 observed Resident 45 exiting Room A, approaching Resident 224 and hitting Resident 224 on the head and RLE with a cane. During a review of Resident 224's Incident Note, dated 6/28/2025, timed at 5:15 p.m., the Incident Note indicated that on 6/28/2025 at 2:45 p.m., Resident 224 was in the hallway (across Room A) sitting in the wheelchair and was yelling. The Incident Note indicated that CNA 11 observed Resident 45 exiting Room A, approaching Resident 224 and hitting Resident 224 on the head and RLE with a cane and that upon further assessment, bruising and swelling were noted on Resident 224's RLE and redness on top of Resident 224's head. The Incident Note indicated Resident 224 complained of mild headache at 3:15 p.m. (on 6/28/2025) and Tylenol 325 mg two tablets were administered to Resident 224 as ordered. During a review of Resident 224's Progress Notes dated 6/29/2025 at 12:10 a.m., 6/29/2025 at 1:08 p.m., 6/30/2025 at 7:04 a.m., 6/30/2025 at 2:49 p.m., and 6/30/2025 at 9:05 p.m., the Progress Notes indicated Resident 224 had bruising present on Resident 224's RLE. During a review of Resident 224's Care Plan (CP) titled, Resident has been involved in an incident on 6/28/2025 (struck by another resident), initiated on 6/30/2025, the CP indicated to provide appropriate pain relief measures, including pharmacological (the use of medications to treat prevent a medical condition) and non-pharmacological (any health intervention that doesn't involve medications) interventions as one of the interventions to maintain resident's safety and comfort. During a review of Resident 224's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure residents were free from unnecessary (any medication in excessive dose, excessive duration, without adequate indication for its use and monitoring) use of psychotherapeutic drug (any medication capable of affecting the mind, emotions, and behavior) in accordance with facility policy and procedures for three (3) of six (6) sampled residents (Residents 2, 19 and 27) by failing to ensure: 1. Resident 2 had specific, measurable target behaviors monitored related to the use of clonazepam (a psychotropic medication used to treat anxiety). As a result, Resident 2 was not monitored for specific behavior with the use of clonazepam, starting 7/11/2025. 2. The use of clonazepam was limited to the use of as needed for 14 days or indicate a specific duration of use. As a result, Resident 2's clonazepam order remained on the Medication Administration Record ([MAR] - a record of medications administered to residents) without a specific duration, starting 5/8/2025. 3. Resident 19 had specific, measurable target behaviors monitored related to the use of Ativan (a psychotropic medication used to treat anxiety [a mental health condition where excessive fear and worry interfere with daily life, causing significant distress]). As a result, Resident 19 was not monitored for specific behavior with the use of Ativan, starting 5/22/2025. 4. Resident 19's use of as needed Ativan was limited to 14 days or with a specific duration of use. As a result, Resident 19's Ativan order remained on the MAR without a specific duration, starting 5/2/2025 and 5/22/2025. 5. Resident 27 was monitored for pulse rate and adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) for the use of Remeron (a type of medication used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest]. As a result, Resident 27 was not monitored for adverse effects and pulse rate and adverse effects for the use of Remeron. These deficient practices had the potential to place Residents 2, 19 and 27 at risk for significant adverse effects from the use of unnecessary psychotherapeutic drugs, which could result in impairment or decline in the residents' mental, physical condition, mental, functional, and psychosocial status. Cross reference F756 Findings:a). During a review of Resident 2’s admission Record (a document containing demographic and diagnostic information,) dated 7/17/2025, the record indicated Resident 2 was originally admitted to the facility on [DATE] with diagnosis including psychosis, depression, anxiety, insomnia (difficulty sleeping) and dementia (a group of conditions that cause a decline in memory, thinking, language, and judgment). During a review of the History and Physical (H&P) report completed on 7/31/2024, indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of the Minimum Data Set (MDS - a resident assessment tool) dated April 15, 2025, the MDS indicated Resident 2 had moderately impaired cognition for daily decision making, had no symptoms of feeling down, depressed or hopeless, and was not marked for having trouble falling asleep, and was taking antipsychotic, antianxiety and antidepressant medications. During a review of Resident 2’s MAR on 7/17/2025, for July 2025, the MAR indicated Resident 2 was prescribed the following medications: 1. Clonazepam 1 milligram ([mg – a unit of measure of mass]) to give one (1) tablet orally every 24 hours “as needed” for anxiety manifested by constantly getting out of bed at night, starting 5/8/2025 without a specific duration. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Clonazepam 0.5 mg to give one (1) tablet orally at bedtime for anxiety for 14 days manifested by impulsive behavior/agitation, at 9 p.m. starting 7/11/2025. b). During a review of Resident 19’s admission Record, the admission Record indicated the facility admitted the resident on 2/24/2021 with diagnoses including Alzheimer’s Disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress). During a review of Resident 19’s Care Plan (CP) titled, “Antianxiety Drug Therapy as needed lorazepam” initiated on 5/2/2025, the CP indicated administer medication as ordered as one of the interventions to decrease episode of restlessness. During a review of Resident 19’s H&P dated 5/4/2025, the H&P indicated Resident 19 did not have the capacity to understand and make decisions. During a review of Resident 19’s MDS dated [DATE], the MDS indicated Resident 19 had minimal difficulty hearing, sometimes had the ability to make self-understood and understand others. The MDS indicated Resident 19 required supervision or touching assistance with eating; substantial/maximal to total assistance from staff with all activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 19’s Order Summary Report, the Order Summary Report indicated the following physician orders: - 5/2/2025 with a discontinued date of 5/5/2025: lorazepam tablet 1 mg give 1 tablet by mouth every 12 hours as needed for manifested by restlessness and agitation - 5/22/2025: Ativan oral tablet 0.5 mg (lorazepam) give 1 tablet by mouth every 12 hours as needed for anxiety. During a review of Resident 19’s Consultant Pharmacist’s MRR created between 5/1/2025 and 5/4/2025, the Consultant Pharmacist’s MRR indicated to clarify the diagnosis with the physician and recommend adding 14 days duration of therapy if clinically indicated or appropriate. During a review of Resident 19’s Consultant Pharmacist’s MRR created between 6/1/2025 and 6/4/2025, the Consultant Pharmacist’s MRR indicated the Ativan order dated 5/22/2025 was missing the behavior and clarify the current order, target behavior and monitoring to ensure behaviors are qualitatively and objectively documented. c). During a review of Resident 27’s admission Record, the admission Record indicated the facility admitted the resident on 8/1/2023 with diagnoses including Alzheimer’s Disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and depression. During a review of Resident 27’s CP titled, “Antidepressant Drug Use,” initiated on 8/14/2023, the CP indicated to administer medication as ordered and monitor for common side effects as a few of the interventions to prevent injury from the medication side effects. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 27’s H&P dated 8/16/2024, the H&P indicated Resident 27 did not have the capacity to understand and make decisions. During a review of Resident 27’s MDS dated [DATE], the MDS indicated Resident 27 had minimal difficulty hearing, sometimes had the ability to make self-understood and understand others. The MDS indicated Resident 27 required substantial/maximal to total assistance from staff with all ADLs. The MDS indicated Resident 27 was taking an antidepressant medication. During a review of Resident 27’s Order Summary Report dated 7/18/2025, the Order Summary Report indicated a physician’s order for Remeron oral tablet (mirtazapine) to give 15 by mg mouth at bedtime for depression manifested by insomnia and poor appetite. During a review of Resident 27’s MAR for 6/2025, the MAR indicated that Resident 27 was not monitored for a pulse rate and adverse effects for the use of Remeron on 6/14/2025 on the night shift. The MAR further indicated the medication was administered on 6/14/2025 at 9 p.m. During an interview on 7/16/2025 at 3:21 p.m., with the Director of Nursing (DON), the DON stated that when the consultant pharmacist emails the MRRs, the task to address the recommendations with the physicians are delegated between the care planners and the RN supervisors and addressed as soon as possible. During a concurrent record review and interview on 7/17/2025 at 11:24 a.m., with Licensed Vocational Nurse (LVN) 15, LVN 15 reviewed Resident 2’s MAR for July 2025. LVN 2 stated Resident 2’s clonazepam 0.5 mg order prescribed at bedtime for anxiety for 14 days manifested by impulsive behavior/agitation does not have a specific type of impulsive behavior/agitation identified. LVN 15 stated there are many different types of impulsive behavior/agitation, such as pushing things, or constantly disrobing. LVN 15 stated psychotherapeutic medications should have specific target behaviors to ensure specific behavior monitoring, otherwise different licensed nursing staff will evaluate different behaviors, and as a result physicians make incorrect assessments for the clonazepam therapy. During the same interview, LVN 15 stated psychotherapeutic medications should be used for short durations to prevent harm to residents by preventing adverse effects, and that “as needed” psychotherapeutic medications should have a specific duration indicated on the physician order. LVN 15 stated that the clonazepam 1 mg order for every 24 hours “as needed” for anxiety prescribed to Resident 2 does not have a specific duration identified. During a concurrent record review and interview on 7/17/2025 at 12:03 p.m., with Registered Nurse (RN) 1, RN 1 reviewed Resident 2’s MAR for July 2025. RN 1 stated Resident 2’s clonazepam 0.5 mg order prescribed for anxiety manifested by impulsive behavior/agitation, does not have a specific type of impulsive behavior/agitation identified. RN 1 stated there are many different types of impulsive behavior/agitation, such as yelling, hitting, and screaming. RN 1 stated psychotherapeutic medications should have indications and monitoring for specific target behaviors to ensure specific behavior monitoring, evaluation of medication effectiveness for specific behavior, and to prevent adverse consequences caused by continuing unnecessary medications. RN 1 stated that without specific targeted behaviors of impulsive behavior/agitation different licensed nurses can interpret and document for different behaviors resulting in the physician making an inaccurate assessment of Resident 2’s medication therapy leading to the use of unnecessary psychotherapeutic medication causing adverse consequences and harming Resident 2. (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same interview, RN 1 confirmed RN 1 was unable to locate a stop date or a specific duration for the clonazepam 1 mg “as needed” order for Resident 2, starting 5/8/2025. RN 1 stated that “as needed” orders for psychotherapeutic medications needed to have a specific duration to ensure that the medications were not causing more harm than good. RN 1 stated that the physician who prescribed the order and the licensed nursing staff who accepted the orders failed to include the duration for the clonazepam 1 mg “as needed” order for Resident 2, starting 5/8/2025. During a concurrent interview and record review on 7/18/2025 9:25 a.m., Resident 19’s electronic health record, physician’s order, and MRR created between 5/1/2025 and 5/4/2025, and 6/1/2025 and 6/4/2025, were reviewed with the Risk Management Nurse (RMN). The RMN stated the MRR dated 5/1/2025 and 5/4/2025 indicated to clarify the diagnosis with the physician and recommend adding 14 days duration of therapy. The RMN stated the pharmacist recommendation created between 5/1/2025 and 5/4/2025 was not followed up and acted upon with the physician to clarify the diagnosis and to add the 14 days duration. The RMN stated the pharmacist recommendation created between 6/1/2025 and 6/4/2025 was not followed up and acted upon with the physician to indicate the behavior manifestation for the use of Ativan. The RMN stated she was unable to find documented evidence that the pharmacist recommendation was addressed with the physician. The RMN stated the monthly pharmacist recommendations are delegated to the care planners and/or RN supervisors to address with the physicians within 1 week. The RMN stated the care planners or RN supervisors assigned should have addressed the pharmacy recommendations with the physician timely. The RMN stated the Ativan order dated 5/2/2025 should have indicated the diagnosis and a duration of 14 days and the Ativan order dated 5/22/2025 should have indicated the specific behavior manifestation to ensure the use of the medication is necessary and not prolonged which placed Resident 19 at risk for adverse effects related to prolonged use of the Ativan. During a concurrent interview and record review on 7/18/2025 at 11:44 a.m., Resident 27’s physician’s orders, MAR for 6/2025, and CP were reviewed with the RMN. The RMN stated Resident 27 was not monitored for pulse rate and adverse effects of the medication for 6/14/2025 night shift. The RMN stated residents are supposed to be monitored for adverse effects of Remeron and documented in the MAR to ensure Resident 27 is monitored appropriately and that the use of the medication is necessary. The RMN stated if Resident 27 was not monitored appropriately or accurately for any adverse effects resulting in the physician making an inaccurate assessment of the antianxiety therapy, leading to unnecessary use of the medication and placed the resident at risk for inaccurate, unmonitored side effects which could lead to risk of falls/injury. During an interview on 7/18/2025 at 12:30 p.m., the Assistant Director of Nursing (ADON) stated that the licensed nurses are required to document in the MAR if the resident had adverse reactions including the pulse rate to ensure accurate assessment of the physician during an evaluation of the behavior episodes as well as notification of the physician for the presence of any adverse reactions. The ADON stated Resident 27’s monitoring of adverse effects and pulse rate for the use of Remeron were not documented in the MAR on 6/14/2025 at 9 p.m. when the medication was administered. The ADON stated the licensed nurse should have monitored Resident 27 for the adverse effects and pulse rate for the use of Remeron. The ADON stated if there was incomplete documentation of the adverse reactions including the pulse rate, the staff including the physician would not know if the resident had any adverse effects or abnormal pulse rate which may lead to inaccurate assessment of the antianxiety therapy. The ADON stated the inaccurate assessment, unmonitored side effects of the Remeron may lead to unnecessary use of the medication which could lead to risk of falls. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/18/2025 at 12:54 p.m., with the DON, and ADON, and in the presence of RMN, the DON stated clonazepam was a psychotherapeutic medication, and that “as needed” psychotherapeutic medications needed to have a specific duration of therapy. The ADON stated the reason for limiting the duration of psychotherapeutic medications was to ensure the medications were re-evaluated for effectiveness of specific behaviors without causing additive side effects, such Tardive Dyskinesia (TD- a disorder characterized by involuntary, repetitive, and uncontrollable movements, often of the face and body, that develop after prolonged use of certain medications) Extra Pyramidal Symptoms ([EPS - a group of side effects that affect movement, often caused by certain medications,]) and not resulting in more harm than benefit leading to the unnecessary use of psychotherapeutic medications. The ADON and DON stated the clonazepam 1 mg “as needed” order for Resident 2 did not indicate a specific duration and needed to be limited to 14 days, placing Resident 2 at risk of receiving unnecessary psychotherapeutic medication. The DON stated the facility failed to identify a stop date or duration for clonazepam 1 mg “as needed” order for Resident 2, starting 5/8/2025. During the same interview, the ADON and DON stated psychotherapeutic medications needed to have a specific behavior linked to the use of the medication for the licensed nursing staff to know exactly what behavior to monitor. The ADON, DON and RMN stated Resident 2’s clonazepam 0.5 mg order prescribed for anxiety manifested by impulsive behavior/agitation did not have a specific type of impulsive behavior/agitation identified. The DON stated that without specific targeted behavior monitoring, assessments and evaluations for the use of clonazepam will be inaccurate, preventing potential medication adjustments, such as lowering the dose or discontinuing the medication leading to unnecessary use and adverse consequences for Resident 2. The ADON and DON stated that the facility failed to identify a specific behavior related to the use of clonazepam 0.5 mg order, placing Resident 2 at risk of receiving unnecessary psychotherapeutic medications. During an interview with the ADON on 7/18/2025 at 2:06 p.m., the ADON stated the care planners and/or RN supervisors are responsible in addressing the pharmacist recommendations with the physicians immediately. The ADON stated the MRR for Resident 19 created between 5/1/2025 and 5/4/2025 indicating to clarify the diagnosis with the physician and recommend adding 14 days duration of therapy and the MRR for 6/1/2025 and 6/4/2025 to indicate the behavior manifestation for the use of Ativan should have been addressed timely with the physician to ensure the use of the medication is necessary and not prolonged which placed Resident 19 at risk for adverse effects related to prolonged use of the Ativan. The ADON stated behavior manifestations should be specific and measurable. The ADON stated the facility policy titled, “Drug Regimen Review,” was not followed. During a review of the facility’s policy and procedures (P&P), titled “Psychotherapeutic Drug Management,” last reviewed 4/28/2025, the P&P indicated: I. The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical, and/or behavioral interventions, as well as medications can be utilized to meet the needs of the individual resident. II. The facility will make every effort to comply with the state and federal regulations related to the use of psychopharmacological medications in the long-term care facility to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	“Psychotropic medications’ – also described as …’psychotherapeutic’ medications, are drugs that affect brain activities associated with mental processes and behavior. They are divided into four broad categories: antipsychotic, antidepressant, antianxiety and hypnotic. ‘Tardive dyskinesia’ – refers to abnormal, recurrent, involuntary movements that may be irreversible and typically present as lateral movements of the tongue or jaw, tongue thrusting, chewing, frequent blinking, brow arching, grimacing, and lip smacking, although the trunk and other parts of the body may also be affected. ‘Unnecessary drugs’ – are any drug used in excessive dose; for excessive duration, without adequate monitoring, or without adequate indications for its use, in the presence of adverse consequences which indicate the dose should be reduced or discontinues or any combinations of the afore listed reasons. C. The psychotherapeutic medication order will include the following information. III. Indications and manifestations of the disorder treated i.e. auditory hallucinations, hitting others, refusing to eat, etc. M. Residents should not receive psychotropic drugs pursuant to a PRN (as needed) order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. i. PRN orders for psychotropic drugs are limited to 14 days. If the Attending physician/LHP believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident’s medical record and indicate the duration for the PRN order. Nursing responsibility: B. Will monitor psychotropic drug use daily noting any adverse effects (such as EPS, tardive dyskinesia, excessive dose or distressed behavior). H. The medication will be written on the MAR with the following information: ii. manifestations for the drug i.e. hitting others etc. “ During a review of the facility’s P&P titled “Psychotherapeutic Drug Management in Residents with Dementia,” last reviewed 4/28/2025, the P&P indicated: II. “To help promote or maintain the resident’s highest practicable mental, physical, and psychosocial well-being, promote resident safety and security, and to enhance the resident’s ability to interact positively with his/her environment III. To ensure the resident receives only those medications, in doses and for the duration clinically indicated to treat the resident’s associated condition(s). V. To ensure clinically significant adverse consequences are minimized. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. to monitor psychotropic drug use daily noting any adverse effects (such as EPD, tardive dyskinesia, and excessive dose or distressed behavior as one of the nursing responsibilities. E. The psychotherapeutic medication order will include the following information. III. Indications and manifestations of the disorder treated i.e. auditory hallucinations, hitting others, refusing to eat, etc.” During a review of the facility’s P&P titled, “Guidelines for Psychotherapeutic Medications, ” last reviewed on 4/28/2025, the P&P indicated that “residents receiving antidepressant drugs shall have behaviors and side effects monitored on the MAR.” During a review of facility P&P titled “Physician Orders,” last reviewed 4/28/2025, the P&P indicated: III. “Medication orders will include the following: D. Duration of order.” During a review of the facility’s policy and procedure (P&P) titled, “Drug Regimen Review, ” last reviewed on 4/28/2025, the P&P indicated: - The facility maintains the residents’ highest practicable level of physical, mental and psychosocial well-being and prevents or minimizes adverse consequences r/t medication therapy to the extent possible by providing oversight by a licensed pharmacist, attending physician (AP), medical director, and the DON. - The consulting pharmacist will report any irregularities such as unnecessary drugs (which include but are not limited to excessive dosage, excessive duration, inadequate monitoring, inadequate indications for use or adverse consequences of use) to the medical director, DON, and the AP. - Irregularities must be addressed in a separate, written report. The report will include the resident’s name, the relevant drug, and the irregularity the pharmacist identified. - The AP will respond to any irregularities reported by the pharmacist by reviewing the irregularities and documenting in the resident’s medical record that the irregularity has been interviewed and what, if any, action has been taken to address it. - If no action has been taken, the attending physician must document his/her rationale. - Documentation by the attending physician must occur within 30 days of the issuance of the pharmacist’s report.”

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to report an allegation of staff to resident abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) immediately, but no later than two hours after the allegation was made to the State Survey Agency (CDPH - California Department of Public Health), the Ombudsman (a resident advocate), and local law enforcement (LLE) in accordance with federal and state law for one of three sampled residents (Resident 16) reviewed under the Abuse care area. This deficient practice had the potential to result in unidentified abuse in the facility and failure to protect residents from harm from abuse. Findings:During a review of Resident 16's admission Record (AR), the AR indicated the facility originally admitted the resident on 9/12/2022 and most recently admitted the resident on 4/17/2025 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), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and unspecified dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life). During a review of Resident 16's Minimum Data Set (MDS - resident assessment tool), dated 6/17/2025, the MDS indicated the resident sometimes was able to understand others and sometimes was able to make themself understood. The MDS further indicated that the resident required substantial/maximal assistance from staff with dressing; and was dependent on staff for toileting, oral and personal hygiene, and bathing. During a review of Resident 16's History and Physical (H&P), dated 6/12/2025, the H&P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 16's Change of Condition (COC) Progress Notes completed by Registered Nurse (RN) 3, dated 7/5/2025 at 4 p.m., the COC Progress Notes indicated Resident 16 reported an allegation of being pushed by a staff member. Monitoring for abuse, neglect, and emotional distress were started and the Director of Nursing (DON) was notified. During a review of Resident 16's Incident Note, dated 7/5/2025 at 4 p.m., completed by RN 3, the Incident Note indicated there would be an investigation of alleged abuse and the Administrator (ADM) was informed. During a review of Resident 16's Order Review History Report, dated 7/17/2025, the Order Review History Report indicated a physician's order to monitor for signs and symptoms of emotional distress, neglect, and abuse every shift for 14 days, dated 7/5/2025. During a review of the facility provided email titled, Allegation of Abuse, dated 7/8/2025, at 10:32 a.m., the email indicated on 7/7/2025 at 10:32 a.m. the ADM reported an allegation of abuse to CDPH, the Ombudsman, and LLE. During a review of the facility provided SOC 341 (a report of suspected dependent adult/elder abuse) form, dated 7/7/2025, the SOC 341 indicated an allegation of alleged abuse had begun for Resident 16. The SOC 341 indicated CDPH, Ombudsman, and LLE were notified. The SOC 341 indicated there were blank information boxes for the date and time CDPH, the Ombudsman, and LLE were notified. During a concurrent interview and record review on 7/16/2025 at 8:35 a.m. with the ADM, the SOC 341 form, dated 7/7/2025, was reviewed. The ADM stated the ADM is the facility abuse coordinator. The ADM stated the facility policy is to immediately, but not later than two hours from learning of the allegation, report an allegation of abuse to CDPH, the Ombudsman, and LLE. The ADM stated the proper authorities should be notified to investigate and ensure the resident is safeguarded. The ADM stated on 7/5/2025 at about 2:45 p. m., CNA 5 reported to LVN 6 that Resident 16 alleged that on 7/4/2025 CNA 7 grabbed Resident 16's hands, crossed the arms on the resident's chest, then pushed on the resident's chest. The ADM stated on 7/5/2025, the ADM was sent a text message that indicated Resident 16 made the allegation of abuse, but the allegation was not reported to CDPH, the Ombudsman, and LLE until 7/7/2025 due to confusion over who would report the allegation. The ADM stated all the facility staff caring for Resident 16 were mandated reporters (someone legally obligated to report suspected abuse or neglect to the appropriate authorities), and it was everyone's job to follow up to ensure the ADM reported Resident16's allegation of abuse at the time of the allegation, but they did not. The ADM stated the facility policy and procedure (P&P) was not followed when Resident 16's allegation of abuse was not reported within 2 hours of learning of the allegation. During an interview on 7/16/2025 at 9:40 p.m. with LVN 6, LVN 6 stated on 7/5/2025 in the morning, Resident 16 made an allegation of abuse. LVN 6 stated LVN 6 reported the allegation of abuse at 2:45 p.m. on 7/7/2025 to RN 3, the ADM, and the DON. LVN 6 stated LVN 6 waited until 2:45 p.m. to report the allegation because LVN 6 wanted to monitor Resident 16. LVN 6 stated the ADM did not respond to LVN 6's text message, but the DON did respond and was aware of the allegation. During an interview on 7/18/2025

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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 interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for four of the five sampled residents (Residents 117, and 106, 72 and 224) by failing to: 1. Ensure a care plan was developed for Resident 117's diagnosis of pneumonia (lung infection). 2. Ensure a care plan was developed for Resident 106's use of azithromycin (antibiotic medication used to treat infection). 3. Ensure a care plan was developed for Resident 72's refusal to remove the wheelchair on top of the floor mat (a cushioned floor pad designed to help prevent injury should a person fall). 4. Ensure a care plan was developed timely for Resident 224's involvement on a resident-to-resident altercation. These failures had the potential to result in delays in the delivery of necessary care and services. Findings:1). During a review of Resident 117’s admission Record, the admission Record indicated the facility admitted Resident 117 on 5/29/2025, with diagnoses that included metabolic encephalopathy (a change in how your brain works due to an underlying condition), unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities) and generalized muscle weakness. During a review of Resident 117’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 6/6/2025, the H&P indicated Resident 117 had fluctuating capacity to understand and make decisions. During a review of Resident 117’s Minimum Data Set (MDS-a resident assessment tool), dated 6/11/2025, the MDS indicated Resident 117’s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. During a review of Resident 117’s Order Audit Report (Physician Order), dated 6/23/2025, the Order Audit Report indicated an order to administer amoxicillin potassium clavulanate (medication used to treat infection) tablet 875-125 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount), one tablet by mouth every 12 hours for bacterial infection/pneumonia for five days. During a concurrent interview, and record review on 7/15/2025, at 9:52 a.m., with the IP, Resident 117’s Care Plans were reviewed. The IP stated there was no care plan developed for Resident 117’s pneumonia. The IP stated a care plan should have been created. The IP stated the care plan indicates the goals and intervention to be provided to the residents. 2). During a review of Resident 106’s admission Record, the admission Record indicated the facility admitted Resident 106 on 4/8/2025, with diagnoses that included Parkinson’s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia and generalized muscle weakness. During a review of Resident 106’s H&P, dated 4/9/2025, the H&P indicated Resident 106 had fluctuating capacity to understand and make decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 106’s MDS, dated [DATE], the MDS indicated Resident 106’s cognitive skills for daily decisions were moderately impaired. During a review of Resident 106’s Order Audit Report, dated 6/3/2025, the Order Audit Report indicated an order to administer azithromycin tablet 250 mg, two tablets by mouth in the afternoon for bronchitis (an inflammation of the bronchial tubes, the airways that carry air to your lungs) for one day and administer one tablet by mouth for four days on day two administer four. During a concurrent interview, and record review on 7/15/2025, at 9:52 a.m., with the IP, Resident 106’s Care Plans were reviewed. The IP stated there was no care plan developed for Resident 106’s use of azithromycin on 6/3/2025. The IP stated care plan should have been created for the use of azithromycin. During an interview on 7/16/2025, at 2:55 p.m., with the Assistant Director of Nursing (DON), the ADON stated a care plan should have been developed for Resident 117’s pneumonia and especially for Resident 106’s use of antibiotics. The ADON stated that without a care plan, it could exacerbate the signs and symptoms of pneumonia or bronchitis or whatever the infection. The ADON stated that without a care plan, nursing care would not be followed because there was no care plan to guide the nurses. During an interview on 7/16/2025, at 4 p.m., with the Director of Nursing (DON), the DON stated a care plan should have been created for the diagnosis of pneumonia and the use of azithromycin. The DON stated the care plan helps the nurses for continuity of care. The DON stated the care plan guides the nurses on how to take care of the residents. The DON stated that without the care plan, infection could not be treated, and infection could prolong. During a review of the facility’s policy and procedure (P&P), titled, “Care Planning” dated 10/24/2022, and last reviewed on 4/28/2025, the P&P indicated, “To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. 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 interdisciplinary team (IDT- a coordinated group of experts from several different fields who work together) work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs…. Changes may be made to the Comprehensive Care Plan on an ongoing basis for the duration of the resident's stay. These subsequent changes will not need to be reflected through updates to the Baseline Care Plan…. IX. 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.” 3). During a review of Resident 72’s admission Record, the admission Record indicated the facility admitted the resident on 1/6/2023, with diagnoses including Alzheimer’s disease (a disease characterized by a progressive decline in mental abilities), age-related osteoporosis (is a condition that weakens bones, increasing the likelihood of fractures), and repeated falls. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 72’s Care Plan (CP) Report titled “At Risk for fall secondary to repeated falls/antihypertensive (medications used to treat high blood pressure, also known as hypertension) medication,” initiated on 1/9/2024, the CP indicated an intervention to keep the environment free of hazards such has wet spots and keep the pathway free from clutter. During a review of Resident 72’s Order Review History Report, dated 2/26/2024, the Order Review History Report indicated an order that Resident 72 may have a floor mat next to the bed to prevent injuries every shift. During a review of Resident 72’s History and Physical (H&P), dated 1/1/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 72’s Minimum Data Set (MDS, a resident assessment tool), dated 5/28/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated the resident required substantial to supervision assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 72’s Fall Risk Assessment, dated 6/3/2025, the Fall Risk Assessment indicated the resident was at a high risk for falls. During a concurrent observation and interview on 7/14/2025, at 2:28 p.m., with Licensed Vocational Nurse (LVN) 7, while inside Resident 72’s room, Resident 72’s floor mat was observed at the right side of the bed with a wheelchair on top of them. LVN 7 stated the resident placed them himself despite explanation of the risks it may bring. LVN 7 stated it was care planned. LVN 7 stated she was aware of the dangers that it could bring to the resident such as a fall with injury. During a concurrent interview and record review on 7/18/2025, with Registered Nurse (RN) 4, Resident 72’s Medical Diagnosis, Order Review History Report, and Care Plan were reviewed. RN 4 stated she cannot find the care plan of the resident refusing to remove the wheelchair on top of the resident’s floor mat. RN 4 stated the floor mat of Resident 72 should be clear of objects or furniture, because it could cause a fall with injury and has to be care planned if the resident refuses to remove the wheelchair on top of the mat. RN 4 stated the care plan serves as a “Bible” for healthcare providers on what interventions that are needed to be done to the resident to provide quality care. During an interview on 7/18/2025, at 1:39 p.m., with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the DON stated they use the floor mat to reduce the injury of a resident’s fall at the facility. The DON stated there should be no equipment or furniture on top of the fall mat as it causes instability of furniture placed on top of them and the furniture can land on the resident causing injury such as skin tears, trauma, and fracture. The DON also added that the furniture or equipment placed on top of the floor mat can damage the mat by creating a permanent dent, or tear on the mat compromising its ability to absorb the impact of the resident’s fall. The DON stated the refusal of the resident to remove the wheelchair on top of the floor mat should be care planned to communicate to the healthcare team that the resident is refusing despite explanation of the risks it could pose on Resident 72. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent policy and procedure (P&P) titled Care Planning, last reviewed on 4/28/2025, the P&P indicated to ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. The Comprehensive Care Plan must be completed within 7 days after completion of the Comprehensive admission Assessment and must be periodically reviewed and revised by a team of qualified persons after each assessment, including comprehensive and quarterly review assessments. During a review of the facility's recent P&P titled Safety-Environmental, last reviewed on 4/28/2025, the P&P indicated to ensure a safe, clean, and hazard-free environment for all residents, in compliance with Title 22 of the California Code of Regulations, promoting their well-being, dignity, and quality of life. During a review of the undated facility-provided Floor Mat 1 Manufacturer’s Specification, the Manufacturer’s Specification indicated when moving equipment across the mat ensure that the wheels are not locked as “dragging wheels” may damage the mat. Avoid sharp materials from contacting the mat. Never leave heavy materials on the mat for an extended amount of time and they may cause a permanent indentation. 4). During a review of Resident 224’s admission Record, the admission Record indicated the facility originally admitted Resident 224 on 3/23/2022 and readmitted in the facility on 5/12/2024 with diagnoses including Alzheimer’s Disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 224’s H&P, dated 5/1/2025, the H&P indicated Resident 224 did not have the capacity to understand and make decisions. During a review of Resident 224’s MDS, dated [DATE], the MDS indicated Resident 224 had severely impaired cognition (mental action or process of acquiring knowledge and understanding), and usually had the ability to make self-understood and to understand others. The MDS indicated Resident 224 required partial/moderate assistance with eating and was totally dependent on staff with all other activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 224’s Change of Condition (COC-(major decline or improvement in a resident’s status that will not resolve itself without intervention) form dated 6/28/2025, the COC form indicated Resident 224 was struck on the head and right lower extremity by another resident (Resident 45) with a cane. During a review of Resident 224’s care plan (CP) titled, “Psychosocial: Altercation Peer to Peer,” was initiated on 6/29/2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, and record review on 7/18/2025, at 9:16 a.m. Resident 224’s electronic health record including care plans, and COC with Registered Nuse (RN) 4. RN 4 stated the resident-to-resident altercation happened on 6/28/2025 on a weekend. RN 4 stated the CP regarding the incident was developed on 6/29/2025. RN 4 stated RN 4 stated she did not develop the CP regarding the incident. RN 4 stated she should have developed the CP after the incident happened. RN 4 stated the purpose of the CP serves as the communication tool between staff to properly care for Resident 224 especially with an incident of physical abuse. RN 4 stated if the care plan was not developed in a timely manner, the staff would not be aware of the proper interventions to take care of the residents which could have affected Resident 224 psychosocially and physically which may lead to a delay in the care the residents needed. During an interview on 7/18/2025 at 10:15 a.m. with the Risk Management Nurse (RMN), the RMN stated the care plan that Resident 224 was involved in a resident-to-resident altercation should have been created on the day of the incident to prevent delay in the delivery of care and services Resident 224 needed as the CP includes the proper intervention necessary to be able to take care of the resident properly. During an interview on 7/18/2025 at 1:39 p.m., with the Director of Nursing (DON) and Assistant DON (ADON), the DON stated care plans should be developed immediately if an incident such as a fall incident and abuse happens even during the weekend. There is no need for the nurses to wait for the care planners to come on the following business day. The DON stated a care plan addressing Resident 224’s altercation with another resident was not developed timely. The ADON stated the care plan for Resident 224 addressing the altercation with another resident should have been developed immediately to ensure that all the interventions needed are in place, that the plan of care is followed, and that the team is aware of what interventions are in place to meet Resident 224’s needs. The DON stated if the care plan was not developed timely, the interventions would be delayed to ensure Resident 224 was protected from the altercation. During a review of facility’s policy and procedure (P&P), titled, “Care Planning,” last reviewed on 4/28/2025, the P&P indicated a purpose to ensure that a comprehensive person-centered care plan is developed for each resident based on their individual assessed needs. The P&P further indicated: - 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 interdisciplinary team (IDT- a coordinated group of experts from several different fields who work together) work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs. - Changes may be made to the Comprehensive Care Plan on an ongoing basis for the duration of the resident's stay. - Each resident’s 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.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility's licensed nursing staff failed to provide care in accordance with professional standards to one of five sampled residents (Resident 6) reviewed for unnecessary medications by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference F760 Findings: During a review of Resident 6's admission Record, the admission Record indicated the facility admitted the resident on 1/27/2017, with diagnoses including long term use of insulin, type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic chronic kidney disease (a kidney disease caused by diabetes), and hyperglycemia (high blood sugar). During a review of Resident 6's History and Physical (H&P), dated 3/15/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 6/3/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and sometimes had the ability to understand others and had severely impaired cognition (a significant and noticeable decline in a person's thinking abilities, making it difficult for them to perform everyday tasks and live independently). The MDS indicated Resident 6 was on a high-risk drug class hypoglycemic medication (a group of drugs used to help reduce the amount of sugar present in the blood). During a review of Resident 6's Order Review History Report, the Order Review History Report indicated an order for: - 3/15/2025 Admelog SoloStar Subcutaneous Solution Pen-injector 100 unit per milliliters (unit/ml, the amount of insulin in a specific volume of liquid) (Insulin Lispro). Inject as per sliding scale (a customized guide that tells someone with diabetes how much insulin to inject before meals or at specific times, based on their current blood sugar level): if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units, subcutaneously before meals related to type 2 diabetes mellitus with hyperglycemia (E11.65). Call MD if fingerstick blood sugar (a blood glucose test mainly screens for diabetes by measuring the level of glucose [sugar] in your blood) is above 400 or below 70. -6/15/2025 Basaglar KwikPen Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine). Inject 60 units subcutaneously in the morning related to type 2 diabetes mellitus with hyperglycemia (E11.65) before meals (AC) breakfast. During a review of Resident 6's Care Plan (CP) Report titled Diabetes Mellitus: At risk for hyper/hypoglycemia (low blood sugar) episodes, initiated on 1/27/2017, the CP indicated an intervention to administer Lispro insulin per sliding scale and Basaglar Kwik pen sq in the morning as ordered. During a review of Resident 6's Location of Administration Report of insulin for 5/2025 to 7/2025, the Location of Administration Report indicated that insulin: -Admelog Solostar Subcutaneous Solution Pen-injector 100 unit/ml was administered on, 5/6/2025 at 4:23 p.m. on the Abdomen-Left Lower Quadrant (LLQ) 5/7/2025 at 6:28 a.m. on the Abdomen-LLQ 5/10/2025 at 4:15 p.m. on the Abdomen-LLQ 5/11/2025 at 6:58 a.m. on the Abdomen-LLQ 5/16/2025 at 4:27 p.m. on the Abdomen-Right Lower Quadrant (RLQ) 5/17/2025 at 6:37 a.m. on the Abdomen-RLQ 5/18/2025 at 4:13 p.m. on the Abdomen-LLQ 5/19/2025 at 6:14 a.m. on the Abdomen-LLQ 6/7/2025 at 4:20 p.m. on the Abdomen-LLQ 6/8/2025 at 4:11 p.m. on the Abdomen-LLQ 6/20/2025 at 4:01 p.m. on the Abdomen-LLQ 6/21/2025 at 5:47 a.m. on the Abdomen-LLQ 6/23/2025 at 4 p.m. on the Abdomen-Left Upper Quadrant (LUQ) 6/24/2025 at 4:42 p.m. on the Abdomen-LUQ 7/8/2025 at 6:33 a.m. on the Abdomen-Right Upper Quadrant (RUQ) 7/8/2025 at 4:28 p.m. on the Abdomen-RUQ -Basaglar KwikPen Subcutaneous Solution Pen-injector 100 unit/ml was administered on, 5/4/2025 at 7:05 a.m. on the Abdomen-RLQ 5/5/2025 at 7:03 a.m. on the Abdomen-RLQ 5/6/2025 at 7:24 a.m. on the Abdomen-RLQ 5/7/2025 at 6:29 a.m. on the Abdomen-LLQ 5/8/2025 at 6:55 a.m. on the Abdomen-LLQ 5/11/2025 at 6:59 a.m. on the Abdomen-LLQ 5/12/2025 at 6:13 a.m. on the Abdomen-LLQ 5/17/2025 at 6:38 a.m. on the Abdomen-RLQ 5/18/2025 at 7:21 a.m. on the Abdomen-RLQ 5/21/2025 at 7:13 a.m. on the Abdomen-RLQ 5/22/2025 at 7:24 a.m. on the Abdomen-RLQ 5/26/2025 at 6:54 a.m. on the Abdomen-LLQ 5/27/2025 at 6:32 a.m. on the Abdomen-LLQ 5/28/2025 at 6:26 a.m. on the Abdomen-RLQ 5/29/2025 at 6:41 a.m. on the Abdomen-RLQ 6/13/2025 at 6:51 a.m. on the Abdomen-LLQ 6/14/2025 at 6:22 a.m. on the Abdomen-LLQ 6/20/2025 at 6:33 a.m. on the

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of 13 sampled residents (Resident 21 and Resident 20) were provided care in accordance with professional standards of practice. For Resident 21 (who was dependent on staff for eating), after the breakfast dining observation, the head-of-bed (HOB) was not elevated which caused an increased risk to Resident 21 for aspiration (when food or liquid goes into the airway instead of the esophagus). For Resident 20, the 72-hour daily shift charting was incomplete when the resident had a change in condition regarding weight loss which caused a potential for Resident 20's oral intake to go unmonitored and further weight loss. Cross reference F726 Findings:a. During a review of Resident 21’s admission Record (AR), the AR indicated the facility admitted Resident 21 on 11/9/2024 with diagnoses including subdural hemorrhage (collection of blood between the brain's outer membrane and the brain itself) without loss of consciousness, Alzheimer’s Disease (a brain disorder that slowly destroys memory and thinking skills, a progressive decline in mental abilities), dementia (a chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning), muscle weakness, and dysphagia (difficulty swallowing). During a review of Resident 21’s care plan titled, “Therapeutic Diet Secondary to Dysphagia, ” initiated on 2/2/2024, the care plan interventions indicated to follow safe swallowing precautions and to have Resident 21 participate in the Restorative Nursing Assistant ([RNA] nursing aide program to help residents maintain their function and joint mobility) dining program for breakfast and lunch. During a review or Resident 21’s Speech Language and Pathology ([SLP] profession aimed in the prevention, assessment, and treatment of speech, language, communicative, and swallowing disorders) Evaluation, dated 4/14/2025, the SLP Evaluation indicated recommendations for a puree diet (food altered into a smooth and creamy texture for people with difficulty chewing or swallowing) and all liquids. The SLP Evaluation indicated strategies to facilitate safety including upright posture for more than 30 minutes after meals. During a review of Resident 21’s Minimum Data Set (MDS- a resident assessment tool), dated 5/25/2025, the MDS indicated Resident 21 had difficulty communicating words or finishing thoughts, usually understood verbal content, and was moderately impaired for daily decision making. The MDS indicated Resident 21 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for eating. During a review of the Physician’s Order, dated 5/27/2025, the Physician’s Order indicated to provide passive range of motion ([PROM] movement of a joint through the ROM with no effort from person) to both arms as tolerated every day shift for Resident 21. The Physician’s Order indicated to provide Resident 21 active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) to both legs as tolerated every day shift, and ambulation with assistance daily as tolerated every day shift. During an observation on 7/16/2025 at 8:28 a.m. in Resident 21’s room, Resident 21 was lying flat while asleep in bed. Resident 21’s breakfast tray was on top of the bedside table and appeared untouched. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 7/16/2025 at 8:59 a.m. in Resident 21’s room, Resident 21’s HOB was elevated in an upright posture while Restorative Nursing Assistant 5 (RNA 5) was sitting in a chair next to Resident 21’s bed. Resident 21 drank milk from an open cup which RNA 5 brought to Resident 21’s mouth. Resident 21 then ate a spoonful of food. RNA 5 stated Resident 21 was holding liquids in the mouth and did not swallow. RNA 5 stated Resident 21 ate 10 percent [%] of the food tray. During a concurrent observation and interview on 7/16/2025 at 9:13 a.m. in Resident 21’s room, RNA 5 lowered Resident 21’s HOB and positioned the bed completely flat. RNA 5 stated the HOB should be slightly elevated after eating but Resident 21 ate almost nothing. RNA 5 proceeded to provide ROM exercises for both arms and legs while Resident 21 lay flat in bed. RNA 5 completed Resident 21’s exercises on 7/16/2025 at 9:30 a.m. Resident 21 continued to lay flat with the HOB lowered completely. RNA 5 stated Resident 21’s HOB should be elevated after eating but did not eat much today. RNA 5 proceeded to slightly elevate Resident 21’s HOB. During an interview on 7/16/2025 at 9:33 a.m., RNA 5 stated the HOB was lowered to a flat position to make Resident 21 more comfortable while providing ROM exercises. RNA 5 stated Resident 21 could choke or vomit if the bed was flat after eating. RNA 5 stated Resident 21 ate a few spoons of food and basically ate nothing. During a review of Resident 5’s SLP Evaluation, dated 7/16/2025, the SLP Evaluation indicated recommendations for a puree diet and thin liquids. The SLP Evaluation also indicated strategies to facilitate safety including upright posture for more than 30 minutes after meals. During a telephone interview on 7/18/2025 at 8:26 a.m. with Speech Language Pathologist (SLP) SLP 1 stated Resident 21’s recommendations for upright posture during meals and more than 30 minutes after meals were to ensure safety, including ensuring the food did not come up the throat and into the trachea (tube-like structure that connects the larynx (voice box) to the lungs) and lungs. SLP 1 stated any type of material that entered the lungs could build up bacteria and result in infection. SLP 1 stated the HOB should be slightly elevated even if Resident 21 ate a small amount. SLP 1 stated Resident 21 should not lay flat after eating because the body did not have time to digest the food, can increase the risk of the food coming back up the throat to aspirate into the lungs, and can increase the risk of aspiration. During an interview on 7/18/2025 at 3:36 p.m. with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the DON stated a resident (in general) should have the HOB raised completely while eating. The DON stated the HOB should remain elevated for at least 30 minutes after eating, even a small amount, to prevent aspiration. The DON stated that placing a resident flat in bed after eating increased the risk of aspiration. The DON stated Resident 21’s ROM exercises could have been completed with the head-of-bed elevated. During a review of the facility’s policy and procedure (P&P) titled, “Eating and Swallowing: Nursing Manual – Restorative Nursing Program,” revised 3/1/2015 and reviewed 4/28/2025, the P&P indicated the RNA would promote safe swallowing through proper positioning and have knowledge of aspiration. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility’s P&P titled, “Care and Services: Nursing Manual – Nursing Care,” revised 7/1/2016 and reviewed 4/28/2025, the P&P indicated the residents were provided with the necessary care and services to maintain the highest level of functioning in an environment that enhances quality of life. b. During a review of Resident 20’s AR, the AR indicated the facility originally admitted Resident 20 on 3/8/2021 and readmitted the resident on 11/29/2024 with diagnoses including dementia, psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), dysphagia, and generalized muscle weakness. During a review of Resident 20’s History and Physical (H&P) dated 5/14/2025, the H&P indicated Resident 20 did not have the capacity to understand and make decisions. During a review of Resident 20’s CP titled, “Therapeutic Diet Secondary to Dysphagia,” last revised on 5/14/2025, the CP indicated to monitor tolerance of food, monitor oral intake by percentage for breakfast, lunch, and dinner, and setup, prompt, supervise, and/or assist resident at mealtime as a few of the interventions in place to prevent further weight loss. During a review of Resident 20’s MDS, dated [DATE], the MDS indicated Resident 20 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding), was able to make her needs known and usually had the ability to understand others. The MDS indicated Resident 20 required setup or clean-up assistance with eating and substantial / maximal assistance to totally dependent on staff with all other activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 20’s Change of Condition (COC -major decline or improvement in a resident’s status that will not resolve itself without intervention) form dated 7/10/2025, the COC form indicated to monitor Resident 20 for 72 hours for weight loss of 16 pounds (lbs – a unit of measurement) over 180 days. During a review of Resident 20’s progress notes from 7/10 - 7/13/2025, there was no documented evidence of a 72 hour monitoring addressing Resident 20’s weight loss. During a concurrent interview and record review on 7/18/2025 at 10:57 a.m., Resident 20’s COC form and progress notes were reviewed with the Risk Management Nurse (RMN). The RMN stated if a resident had a change in condition, licensed nurses would do a shift charting for 72 hours and should include what happened or what was the problem, vital signs, family and physician notification, and the response from the physician. The RMN stated at each station there was a paper on a clipboard to list the name of residents who had a COC or require special charting, and the charting should be done every shift for 72 hours. The RMN stated the RN supervisor or whoever wrote the COC on the resident would write the resident’s name on the form which would serve as a form of communication between the outgoing and incoming charge nurse. The RMN stated there was no documented evidence Resident 20 was monitored every shift for 72 hours addressing the resident’s weight loss of 16 lbs. in 180 days. The RMN stated the last progress note documented for Resident 20 in the electronic health record was 7/5/2025 at 8:39 p.m. for behavioral changes. The RMN stated the shift charting monitoring Resident 20’s weight loss should have been done for 72 hours to ensure Resident 20’s intake was monitored, resident was encouraged to eat, assisted with eating, and offered alternatives if refusing meals which could lead to further weight loss. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/2025 at 2:30 p.m., the ADON stated for any change in resident's condition, charting the resident's name was placed on a clipboard at the nurses’ station on the list of residents who needed shift charting for 72 hours. The ADON stated the RN supervisors also had their own list in their binder. The ADON stated the purpose of the charting list was to remind the charge nurse of the residents that had a recent COC or residents who required special charting and were supposed to be documented every shift for 72 hours under the progress notes in the electronic health record. The ADON stated Resident 20’s 72-hour charting was not done from 7/10 to 7/13/2025 addressing the resident’s weight loss. The ADON stated Resident 20’s 72-hour shift charting should have been done to ensure the amount of Resident 20’s oral intake was monitored, offered assistance when needed, and offered alternatives if refusing meals. The ADON stated if Resident 20 was not monitored properly, it could lead to further weight loss. During a review of the facility’s P&P titled, “Documentation – Nursing, last reviewed on 4/28/2025, the P&P indicated a purpose to provide documentation of resident status and care given by the nursing staff. The P&P further indicated alert charting was documentation done to track a medical event for a period of 72 hours or longer. Events may include but are not necessarily limited to suspected or actual change in condition. Alert charting describes what was going on such as the resident's condition, use the resident's own words if needed, describe what was done in response to what was going on with the resident, and describe how the resident responded to the actions. During a review of the facility’s P&P titled, “Change of Condition,” last reviewed on 4/28/2025, the P&P indicated an acute change of condition was a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. A licensed nurse would document each shift for at least 72 hours. Documentation pertaining to change in the resident's condition would be maintained in the resident's medical record and on the 24-hour report.

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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 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents with pressure ulcers/injury (a skin and tissue injury caused by prolonged pressure on the skin, often over bony areas) receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for one of three sampled residents (Resident 15) by failing to ensure weekly wound assessment was done for Resident 15's stage 2 pressure injury (it involves a break in the skin's outer layer [epidermis] and some damage to the underlying layer [dermis] on the coccyx (the last bone at the bottom [base] of the spine). The deficient practices had the potential for delay of necessary care and services and worsening of pressure injury to residents. Findings: During a review of Resident 15's admission Record, the admission Record indicated the facility admitted the resident on 3/23/2021, with diagnoses including peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), muscle weakness, and functional urinary incontinence (a state in which an individual cannot get to or use a toilet in time to urinate). During a review of Resident 15's History and Physical (H&P), dated 4/15/2025, the H&P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 15's Minimum Data Set (MDS, a resident assessment tool), dated 4/20/2025, the MDS indicated the resident usually had the ability to make self understood and understand others and had moderately impaired cognition (is a significant decline in mental abilities that noticeably affects daily life). The MDS indicated Resident 15 had impaired upper and lower extremities and uses a wheelchair to mobilize. The MDS indicated Resident 15 was dependent to requiring substantial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 15 was always incontinent of urine and bowel movement. The MDS indicated Resident 15 had an unhealed stage 2 pressure injury and was on a skin and ulcer/injury treatments. During a review of Resident 15's Physician's Order Sheet, dated 4/4/2025, the Physician's Order Sheet indicated an order for low air loss (LAL) mattress (a type of specialized bed that helps prevent and treat pressure ulcers [bed sores] by circulating air through tiny holes in the mattress surface) every (q) shift for pressure injury. Cleanse Stage 2 pressure injury on coccyx with normal saline (NS, a simple solution of salt and water), apply Triad wound dressing (is a special kind of wound dressing that comes as a thick paste), cover with dry dressing (DD) and secure with tape daily (qd) for (X) 24 days for pressure injury. During a review of Resident 15's Braden Scale- For Predicting Pressure Sore Risk, dated 4/7/2025, the Braden Scale indicated the resident was high risk for pressure sore/injury development. During a review of Resident 15's Wound Assessment, the Wound Assessments indicated on: - 4/7/2025, the Wound Assessment indicated Resident 15 had a stage 2 pressure injury at the coccyx measuring 1.5 centimeters (cm, a unit of measurement) (length, L) X 1 cm (width, W) X 0. 2 cm (depth, D) and indicated a plan of care to offload area, stable, continue treatment, prognosis is fair and follow up in 1 week. -4/8/2025 to 4/14/2025, no Wound Assessments found. (Second and third week of April 2025) -4/20/2025 to 4/26/2025, no Wound Assessment found. (Fourth week of April 2025) -4/27/2025 to 5/3/2025, no Wound Assessment found. (Fifth week of April to beginning of May 2025) -5/5/2025, the Wound Assessment indicated Resident 15 had a stage 2 pressure injury on the coccyx that had been resolved. During a review of Resident 15's Care Plan (CP) Report titled Pressure Injury Stage 2- Coccyx, initiated on 4/4/2025, the CP indicated interventions to monitor for signs and symptoms (s/s) of infection: swelling, redness, drainage, odor, notify MD promptly if occurs, monitor for pain/discomfort and provide pain management as needed- per protocol, and notify MD if treatment is ineffective. During a concurrent interview and record review on 7/16/2025, at 2:18 p.m., with Treatment Nurse (TN) 1, reviewed Resident 15's Medical Diagnoses, Physician's Order Sheet, Wound Assessments, Braden Scale, and Care Plan. TN 1 stated she does the Wound Assessments weekly with the Physician Assistant (PA). TN 1 stated she assesses the residents with pressure injury thoroughly including measuring the wounds length, width, and depth. TN 1 stated the pressure injury of Resident 15 was community acquired and was discovered on 4/4/2025 and was provided treatment by the physician. TN 1 stated the resident was hospitalized from [DATE] to 4/14/2025, and she was not able to do her Weekly Wound Assessment on the week of 4/20/2025 to 4/26/2025 and 4/27/2025 to 5/3/2025. TN 1 stated she had seen the resident on 5/5/2025 and the pressure injury on the coccyx was healed and they resolved the pressure ulcer. TN 1 stated she missed 2 weekly Wound Assessments on the resident. TN 1 stated it was important to do Weekly Wound Assessments to monitor the

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide range of motion ([ROM] full movement potential of a joint) exercises to one of five sampled residents (Resident 240) with positioning and mobility (ability to move) concerns by failing to provide active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) exercises to Resident 240's right ankle and left leg in accordance with the physician's order and care plan. This failure had the potential for Resident 240 to develop weakness and ROM limitations. Findings: During a review of Resident 240's admission Record, the admission Record indicated the facility admitted Resident 240 on 4/11/2024 with diagnoses including congestive heart failure (heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), age-related cognitive (ability to think, understand, learn, and remember) decline, and muscle weakness. During a review of Resident 240's physician's orders, dated 8/9/2024, the physician's orders indicated to provide AAROM to both arms daily as tolerated and Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) to apply the right-hand wrist/hand/finger orthosis ([WHFO] material secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist and prevent contractures) as tolerated daily. Another physician's order, dated 10/28/2024, indicated for Resident 240 to receive AAROM to both legs daily as tolerated and sit-to-stand using the handrail in the hallway with the right knee brace (medical device designed to provide support, stability, and protection to the knee joint) on daily as tolerated. During a review of Resident 240's care plan titled, Sit to Stand Transfers Using Handrail with R(ight) Knee Brace On/AAROM Exercises to Upper and Lower Extremities (arms and legs) Due to Limitations of Elbows, Shoulders, Hips, Knees, Ankles and Feet, initiated on 5/13/2025, the care plan interventions included to perform AAROM exercises to both arms and legs, eight to ten (8-10) repetitions, seven times per week as tolerated, apply the right WHFO for 45 minutes or as tolerated daily, and to assist resident to perform sit-to-stand transfers using the handrail with maximum assistance (required between 51 to 75% physical assistance to perform the task) using safety belt (assistive device placed around a person's waist to assist with safe transferring between surfaces or while walking) and right knee brace. During a review of Resident 240's Restorative Nursing Program (RNP) Referral/Care Plan, dated 5/13/2025 by Physical Therapist 2 ([PT 2] professional aimed in the restoration, maintenance, and promotion of optimal physical function), the RNP Referral/Care Plan indicated Resident 240 was at risk for decreased ROM and weakness on both legs. The RNP Referral/Care Plan goal included to maintain ROM and strength to both legs with the provision of AAROM exercises on both legs and sit-to-stand transfers using the handrail with maximum assistance and the right knee brace as tolerated. During a review of Resident 240's Minimum Data Set ([MDS] a resident assessment tool), dated 6/30/2025, the MDS indicated Resident 240 had clear speech, expressed ideas and wants, understood verbal content, and had moderately impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 240 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms and legs and required substantial/maximal assistance (helper does more than half the effort) for upper and lower body dressing, sit-to-stand transfers, and chair/bed-to-chair transfers. During an observation on 7/15/2025 at 1:11 p.m. in Resident 240's room, Resident 240's head-of-bed was elevated and was sleepy with difficulty opening both eyes. There was a green hand splint observed on the bedside table. During an observation on 7/15/2025 at 1:28 p.m. in Resident 240's room, Resident 240's RNA session with Restorative Nursing Assistant 4 (RNA 4) was observed. Resident 240 was drowsy and sleepy throughout the RNA session. RNA 4 performed ROM exercises to the right shoulder, elbow, wrist, hand and the right hip and knee. RNA 4 did not perform any ROM exercises to the right ankle. RNA 4 moved to the left side of Resident 240's bed and began performing left shoulder ROM. Resident 240 complained of left shoulder pain, and RNA 4 stopped providing ROM exercises. RNA 4 did not provide any ROM exercises to the left elbow, wrist, hand, hip, knee, and ankle joints. RNA 4 then applied Resident 240's right-hand WHFO. During an interview on 7/15/2025 at 1:38 p.m. with RNA 4, RNA 4 stated Resident 240 received AAROM exercises to the arms and legs and applied right-hand WHFO. RNA 4 stated Resident 240 had physician's order to perform sit-to-stand but was not awake enough today to perform sit-to-stand exercises. RNA 4 stated Resident 240 did not receive ROM to the left arm due to Resident 240's complaint of left arm pain. RNA 4 stated she forgot to

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received necessary care and services to prevent accidents for two of seven sampled residents (Resident 72 and 4). For Resident 72, who had repeated falls, the floor mat (a cushioned floor pad designed to help prevent injury should a person fall) had furniture or medical equipment on top of it. For Resident 4, who had a high risk of fall, there was no fall risk assessment completed after the resident fell on 4/24/2025. These deficient practices caused an increased the risk of accidents and fall with injury. Cross Reference F656 Findings:a. During a review of Resident 72’s admission Record, the admission Record indicated the facility admitted the resident on 1/6/2023, with diagnoses including Alzheimer’s disease (a disease characterized by a progressive decline in mental abilities), age-related osteoporosis (a condition that weakens bones, increasing the likelihood of fractures), and repeated falls. During a review of Resident 72’s Care Plan (CP) Report titled “At Risk for fall secondary to repeated falls / antihypertensive medication (drugs used to treat high blood pressure, also known as hypertension),” initiated 1/9/2024, the CP indicated an intervention to keep environment free of hazards and keep the pathway free from clutter. During a review of Resident 72’s Order Review History Report, dated 2/26/2024, the Order Review History Report indicated Resident 72 may have floor mat next to bed to prevent injuries every shift. During a review of Resident 72’s History and Physical (H&P), dated 1/1/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 72’s Minimum Data Set (MDS, a resident assessment tool), dated 5/28/2025, the MDS indicated the resident had the ability to make self-understood, understood others, and had intact cognition (no problems with thinking, remembering or using judgment). The MDS indicated the resident required substantial to supervision assistance for mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 72’s Fall Risk Assessment, dated 6/3/2025, the Fall Risk Assessment indicated the resident was a high risk for falls. During a concurrent observation and interview on 7/14/2025, at 2:28 p.m., with Licensed Vocational Nurse (LVN) 7, inside Resident 72’s room, Resident 72’s floor mat was at the right side of the bed with a wheelchair on top of it. LVN 7 stated the resident placed the wheelchair on top of the floor mat himself, despite explanation of the risks it may bring. LVN 7 stated she was aware of the dangers that it could bring to the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/18/2025, with Registered Nurse (RN) 4, Resident 72’s Medical Diagnosis, Order Review History Report, and Care Plans were reviewed. RN 4 stated she could not find the care plan of the resident refusing to remove the wheelchair on top of the resident’s floor mat. RN 4 stated the floor mat of Resident 72 should be clear of objects or furniture because it could cause a fall with injury and had to be care planned if the resident refused to remove the wheelchair. RN 4 stated the care plan served as guidance for healthcare providers on what interventions were needed to provide quality care to Resident 72. During an interview on 7/18/2025, at 1:39 p.m., the Director of Nursing (DON) stated they used the floor mat to reduce the injury of a resident’s fall at the facility. The DON stated there should be no equipment or furniture on top of the fall mat as it caused instability, and the furniture could land on the resident causing injury. The DON added that the furniture or equipment placed on top of the floor mat can damage the mat by creating a permanent dent, or tear on the mat compromising its ability to absorb the impact of the resident’s fall. The DON stated the refusal of Resident 72 to remove the wheelchair on top of the floor mat should be care planned to communicate to the healthcare team that the resident refused despite explanation of the risks it could pose. During a review of the facility's recent policy and procedure (P&P) titled, Safety-Environmental, last reviewed on 4/28/2025, the P&P indicated to ensure a safe, clean, and hazard-free environment for all residents, in compliance with Title 22 of the California Code of Regulations, promoting their well-being, dignity, and quality of life. During a review of the facility's recent P&P titled, Care Planning, last reviewed on 4/28/2025, the P&P indicated to ensure that a comprehensive person-centered Care Plan was developed for each resident based on their individual assessed needs. The Comprehensive Care Plan must be completed within 7 days after completion of the Comprehensive admission Assessment and must be periodically reviewed and revised by a team of qualified persons after each assessment, including the comprehensive and quarterly review assessments. During a review of the facility-provided Floor Mat 1 Manufacturer’s Specification, undated, the Manufacturer’s Specification indicated when moving equipment across the mat, ensure the wheels were not locked as “dragging wheels” may damage the mat. Avoid sharp materials from contacting the mat. Never leave heavy materials on the mat for an extended amount of time as they may cause a permanent indentation. b. During a review of Resident 4’s admission Record, the admission Record indicated the facility originally admitted the resident on 3/21/2023 and readmitted on [DATE] with diagnoses including chronic congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), Alzheimer’s disease (a disease characterized by a progressive decline in mental abilities), and dementia (a progressive state of decline in mental abilities). During a review of Resident 4’s History and Physical (H&P), dated 2/26/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 4’s Fall Risk assessment dated [DATE], the assessment indicated the total score of 10 or above represents high risk for fall, and Resident 4 had a total score 24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Registered Nurse (RN) / Licensed Vocational Nurse (LVN) Progress Notes, dated 4/24/2025 the RN/LVN notes indicated Resident 4 was on the floor mat, the bed was in low position, and the resident was unable to explain what happened. During a review of Resident 4’s MDS dated [DATE], the MDS indicated the resident had minimal difficulty hearing, clear speech, usually could make self-understood and had the ability to usually understand others. The MDS indicated the resident had moderately impaired cognitive skills (able to think, remember and use judgement) for decision-making that required cues or supervision. The MDS indicated the resident required maximal assistance with sit to stand and from lying to sitting on the side of bed. During a review of Resident 4’s Fall Risk assessment dated [DATE] indicated the total score of 10 or above represents high risk for fall, and Resident 4 had a total score 24. During a concurrent interview and record review on 7/17/2025 at 1:34 p.m., with the Assistant Director of Staff Development, Resident 4’s Registered Nurse (RN) / Licensed Vocational Nurse (LVN) Progress Notes, dated 4/24/2025 were reviewed. The ADSD stated the RN/LVN progress notes indicated the resident’s roommate stated Resident 4 was sitting on the edge of the bed and slid down from the bed to floor mat. During a concurrent interview and record review on 7/17/2025 at 1:44 p.m., with the ADSD, the Fall Assessments were reviewed. The ADSD stated for Resident 4 there was no fall assessment completed after the 4/24/2025 fall incident. During an interview on 7/18/2025 at 9:46 a.m., the ADSD stated Fall Risk Assessments were done to get a status on the resident’s fall risk level. The ADSD stated the score of 10 and above would be a high risk for fall. The ADSD stated the fall risk score shows what interventions would be implemented and discussed during the interdisciplinary (IDT) meetings. The ADSD stated the Fall Risk Assessment was completed upon admission, quarterly, and after fall incidents. The ADSD stated that when the Fall Risk Assessment was not completed, they could miss doing further evaluations for Resident 4 and Resident 4 could have a repeat fall and potential for decline. During an interview on 7/18/2025 at 1:39 p.m., the Assistant Director of Nursing (ADON) stated there was no post-fall assessment completed after Resident 4’s fall incident on 4/24/2025 and the fall risk scores were used to identify all the residents that were high risk and have potential for falls. During a review of the facility’s policy and procedure (P&P) titled, “Fall Risk Assessment, ” last reviewed on 4/27/2025, the P&P indicated the facility would ensure the resident’s environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents. The facility assesses all residents upon admission and periodically for their risk of falling. The P&P indicated the facility used this information to develop both individualized plans of care and facility-wide fall prevention measures. The P&P indicated the licensed nurse would use the fall risk assessment form to help identify individuals with a history of falls and risk factors for subsequent falling. The P&P indicated the assessment would be completed upon admission, quarterly, and with a significant change in condition.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided to residents consistent with professional standards of practice for three of four sampled residents (Resident 53, 72, and 114), reviewed for Respiratory care by failing to: -Ensure Resident 53's oxygen concentrator (a medical device that provides supplemental oxygen) was turned on to administer as needed (PRN) oxygen on 7/14 and 7/15/2025. -Ensure Resident 72's nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) tubing and mask was off of the floor. -Ensure Resident 114's nasal cannula (a simple, two-pronged device that delivers extra oxygen to the nose) tubing was not touching the floor. These deficient practices had the potential for residents to develop breathing complications and respiratory infections. Findings:a. During a review of Resident 53’s admission Record, the admission Record indicated the facility admitted the resident on 5/15/2021 and readmitted the resident on 11/15/2024 with diagnoses including congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), and pulmonary hypertension (a type of high blood pressure that affects the arteries in the lungs and the right side of the heart). During a review of the Physician’s Order Review History Report dated 11/15/2024, the Order Review History Report indicated Resident 53 to receive Oxygen at three liters per minute (LPM, the liters of liquid moved in one minute) via nasal cannula (NC - a small plastic tube, which fits into the person’s nostrils for providing supplemental oxygen) as needed for shortness of breath (SOB). During a review of Resident 53’s Care Plan (CP) titled, “COPD / Respiratory Disorder / Pulmonary Hypertension at Risk for Dyspnea (difficulty breathing) / wheezing: at risk for SOB,” initiated 11/20/2024, the CP indicated an intervention to have O2 available at all times and administered per protocol. During a review of Resident 53’s Minimum Data Set (MDS, a resident assessment tool), dated 5/19/2025, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS further indicated the resident required partial/moderate assistance with toileting, dressing, and personal hygiene. During a review of Resident 53’s Medication Administration Record (MAR) Progress Notes for 7/2025, the MAR Progress Notes indicated the following: -On 7/14/2024 at 9:43 a.m., Licensed Vocational Nurse (LVN) 13 administered PRN O2 to Resident 53 for SOB. -On 7/14/2025 at 2:12 p.m. LVN 13 documented the PRN administration of O2 was effective. -On 7/15/2024 at 8:15 a.m., LVN 13 administered PRN O2 to Resident 53 for SOB. -On 7/15/2025 at 2:59 p.m. LVN 13 documented the PRN administration of O2 was effective. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/14/2025 at 1:18 p.m., Resident 53 was observed lying in bed with a NC administered at the resident’s nose. The resident groaned slightly and stated he (Resident 53) was breathing ok and needed the O2 via NC every day. Resident 53 was observed with the O2 concentrator turned off and the flow meter (measures and regulates the flow rate of O2 being delivered to a patient) indicated there was no supplemental O2 via NC being administered to Resident 53. During a concurrent observation and interview on 7/15/2025 at 9:10 a.m., with Resident 53 and Certified Nursing Assistant (CNA) 10, Resident 53 was observed sitting in the Dining Room with a NC administered at the resident’s nose. CNA 10 stated Resident 53 had been in the Dining Room for a few minutes and the resident was always administered supplemental O2 via NC while in the Dining Room. Resident 53 stated his breathing was not good. During a concurrent observation, the O2 concentrator was not turned on and the flow meter indicated there was no supplemental O2 via NC being administered to Resident 53. CNA 10 stated the concentrator was not turned on and CNA 10 then turned on the concentrator and the flow meter indicated 3 LPM being administered to the resident. CNA 10 stated usually the Licensed Vocational Nurse (LVN) turns on the concentrator when the resident was brought to the Dining Room. During an interview on 7/15/2025 at 9:23 a.m., LVN 13 stated when Resident 53 complained of SOB, LVN 13 administers PRN O2 via NC, and then LVN 13 reevaluated the effectiveness of the PRN O2 and removed the NC if the resident no longer complained of SOB. LVN 13 stated if Resident 13 had the NC on, then the O2 concentrator should be turned on. LVN 13 stated Resident 13 needed PRN O2 on and off. LVN 13 stated on 7/15/2025 during Resident 53’s breakfast, LVN 13 placed Resident 53 on PRN O2 because the resident complained of SOB. LVN 13 stated Resident 53 went to the Dining Room with PRN O2 due to SOB and the concentrator should have been turned on. LVN 13 stated it was the LVN’s responsibility to turn on the NC. During a concurrent interview and record review on 7/18/2025 at 1:40 p.m. with the Assistant Director of Nursing (ADON) and Director of Nursing (DON), the ADON and DON reviewed the facility policy and procedure regarding O2 administration. The ADON stated it was important to ensure the O2 concentrator was turned on when administering PRN O2 to maintain the resident’s breathing and vital signs (measurements of the body's most basic functions including body temperature, heart rate, respiratory rate, oxygen saturation [measurement of oxygen in the blood], and blood pressure). The DON stated when a resident needs PRN O2 and the concentrator was not turned on it could potentially lead to an exacerbation (COPD respiratory symptoms become much more severe) potentially resulting in a transfer to the acute care hospital. The DON stated the P&P was not followed when Resident 53’s O2 concentrator was not turned on. During a review of the facility P&P titled, “Oxygen Administration,” last reviewed 4/28/2025, the P&P indicated the purpose was to prevent or reverse hypoxemia (a condition characterized by low levels of oxygen in the blood) and provide oxygen to the tissues. The procedure indicated to attach oxygen tubing to the nozzle on the flowmeter, turn on the oxygen at the prescribed rate, and check that oxygen was flowing through the tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 72’s admission Record, the admission Record indicated the facility admitted the resident on 1/6/2023, with diagnoses including urinary tract infection (UTI, common infections that happen when bacteria, often from the skin or rectum, enter the urethra and infect the urinary tract), Escherichia coli (e. coli, is a type of bacteria that commonly lives in the intestines of humans and animals), and Alzheimer’s disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 72’s MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (able to think, remember, and understand). During a review of Resident 72’s Discontinued Order, dated 7/2/2025, the Discontinued Order indicated an order for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligrams per 3 milliliters (mg/ml, a way to express the concentration of a substance) (Ipratropium-Albuterol). 1 unit (refers to a single, pre-measured dose of the drug) inhale orally via nebulizer every 8 hours for metabolic acidosis (a condition where there is too much acid in the body, specifically in the blood and other body fluids) for two weeks. During a review of Resident 72’s Resolved CP Report titled, “Bronchitis (an inflammation of the lining of your bronchial tubes) with cough: at risk for shortness of breath (SOB),” resolved on 4/9/2024, the CP indicated an intervention to administer hand held nebulization (HHN, deliver medicines in the form of aerosols to add moisture and help control your respiratory symptoms) treatment with Albuterol every (q) 6 hours for (X) 10 days as ordered and notify MD if ineffective. During a concurrent observation and interview on 7/14/2025, at 2:28 p.m. with LVN 7, inside Resident 72’s room, observed Resident 72 had a nebulizer at the bedside with the tubing and mask on the floor. LVN 7 stated the tubing, and the mask should not be on the floor as the floor was dirty and it could contaminate the mask and the tubing that delivered the treatment via the mouth and the nose. LVN 7 stated the tubing and the mask if used could cause respiratory infection to Resident 72. LVN 7 stated the mask should be discarded and replaced with a new one. During an interview on 7/18/2025, at 10 a.m., Registered Nurse (RN) 4 stated the treatment nurses were responsible for ensuring the tubing and the mask were stored inside a plastic bag and labeled with the name of the resident and the date it was last changed and kept off the floor to prevent infection to Resident 72. RN 4 stated using a contaminated tubing and mask in delivering an inhalation medication can cause respiratory infection to Resident 72. During an interview on 7/18/2025, at 1:39 p.m., the ADON stated it was not acceptable for the nebulizer tubing and mask to be on the floor or touching the floor because it can cause respiratory infection to Resident 72. The ADON stated the bacteria can crawl into the tubing and into the mask that can cause respiratory infections such as pneumonia (an infection/inflammation in the lungs) and upper respiratory tract infection (URI, a viral or bacterial infection that affects the nose, throat, and sinuses). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During a review of Resident 114’s admission Record, the admission Record indicated the facility admitted the resident on 4/11/2025, with diagnoses including heart failure (occurs when the heart muscle does not pump blood as well as it should), chronic obstructive pulmonary disease (COPD, a group of lung conditions that make it hard to breathe), and Alzheimer’s disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 114’s H&P, dated 4/15/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 114’s MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had severe cognitive impairment (a person has significant difficulties with thinking, learning, remembering, and making decisions). The MDS indicated the resident was on oxygen therapy. During a review of Resident 114’s Order Review History Report, dated 4/11/2025, the Order Review History Report indicated an order for oxygen (O2) three liters per minute (L/min, measurement of how much liquid or gas flows past a certain point in one minute) via nasal cannula as needed for shortness of breath. During a review of Resident 114’s CP Report titled, “COPD: At risk for shortness of breath, ” initiated on 4/15/2025, the CP indicated an intervention to monitor for episodes of shortness of breath, measure pulse oximetry (a simple, non-invasive way to check how much oxygen is in the blood and the heart rate) as needed, administer oxygen via nasal cannula at 3 L/min as ordered, and to notify MD if ineffective. During a concurrent observation and interview on 7/14/2025, at 2:45 p.m., with CNA 4, inside Resident 114’s room, Resident 114’s oxygen tubing via nasal cannula was touching the floor. CNA 4 stated the oxygen tubing should not be touching the floor to prevent respiratory infection, and the tubing was dated 7/6/2025. CNA 4 stated the tubing should have been changed as they change them weekly. CNA 4 stated he would report the incident to his Charge Nurse. During an interview on 7/18/2025, at 10 a.m., RN 4 stated the treatment nurses were responsible for ensuring the tubing was stored inside a plastic bag, labeled with the name of the resident, the date it was last changed, and kept off the floor to prevent infection to Resident 114. RN 4 stated using a contaminated tubing in delivering an oxygen therapy can cause respiratory infection to Resident 114. During an interview on 7/18/2025, at 1:39 p.m., the ADON stated it was not acceptable for the nasal cannula tubing to be touching the floor because it can cause respiratory infection to Resident 114. The ADON stated the bacteria can crawl to the tubing that can cause respiratory infections such as pneumonia and URI. During a review of the facility's recent P&P titled, Oxygen Administration, last reviewed on 4/28/2025, the P&P indicated to prevent or reverse hypoxemia and provide oxygen to the tissues: -All oxygen tubing, humidifiers, masks, and cannulas used to deliver oxygen: -Are for single resident use only. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Will be changed weekly and when visibly soiled. The P& P indicated oxygen items would be stored in a plastic bag at the resident's bedside which was labeled with the resident's name and date when O2 cannula was changed for correct identification and to protect the equipment from dust and dirt when not in use.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to effectively manage a resident's pain for one of six sampled residents (Resident 21) reviewed during the nutrition care area by failing to ensure Treatment Nurse (TN) 2 assessed for pain before, during, and after indwelling catheter (a flexible tube placed in the bladder to drain urine) care (the act of cleaning) when the resident displayed facial grimacing/moaning on 7/17/2025. This deficient practice resulted in Resident 21's undetected pain after catheter care, potentially resulting in a negative effect on the resident's quality of life. Findings: During a review of Resident 21's admission Record (AR), the AR indicated the facility originally admitted the resident on 1/18/2024 and most recently admitted the resident on 11/9/2024 with diagnoses that included metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), carcinoma in situ of vulva (abnormal cells are found on the surface of the vulvar [external female genitals] skin), malignant neoplasm (cancer) of unspecified site of female breast, and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 21's History and Physical (H&P), dated 4/11/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 21's Minimum Data Set (MDS - resident assessment tool) dated 5/5/2025, the MDS indicated the resident usually was able to understand others and usually was able to make herself understood. The MDS further indicated Resident 21 was dependent on staff for eating, toileting, bathing, dressing, oral and personal hygiene, and mobility. During a review of Resident 21's Order Review History Report, the Order Review History Report indicated the following physician's orders: 1. Indwelling catheter care, cleanse with ready bath bathing cloths (2 Licensed Vocational Nurses [LVN] required), every 12 hours and as needed, dated 7/11/2025. 2. Monitor for pain, every shift, dated 1/18/2025. 3. Acetaminophen Oral Tablet 325 milligrams (MG - a unit of measurement), give 2 tablets by mouth every 4 hours as needed, for mild pain or general discomfort, not to exceed 3 grams (GM - a unit of measurement) in 24 hours from all sources, dated 1/18/2025. During a review of Resident 21's Care Plan (CP) regarding the resident's history of malignant neoplasm of the right breast and carcinoma in situ of vulva, initiated 1/19/2025, the CP indicated the resident was at risk for pain with a goal that the resident would have no excessive pain. The CP indicated interventions to encourage the resident to verbalize feelings and concerns and try to resolve concerns. During a review of Resident 21's CP regarding excoriation (the mechanical removal or abrasion of the skin's surface layer, resulting in the skin appearing red, raw, or with irritated patches) in the perineal area (area of the body between the anus and the external genitalia), initiated 4/1/2025, the CP indicated interventions to provide perineal care after each episode of incontinence. During an interview on 7/17/2025 at 7:40 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated CNA 2 has been caring for Resident 21 for about two months. CNA 2 stated Resident 21's skin has redness in the perineal area where the nurses apply cream. CNA 2 stated it seems like Resident 21 has a problem in that area that causes pain when CNA 2 cleans the resident after having a bowel movement. During a concurrent observation and interview on 7/17/2025 at 9:30 a.m. with TN 2, LVN 5, LVN 6, and CNA 2; observed Resident 21's indwelling catheter care. TN 2 stated Resident 21 had a history of excoriation that had previously healed but had just returned. Observed TN 2 explained to Resident 21 that catheter care would be provided while Resident 21 lay in bed. Observed Resident 21 did not verbally communicate with TN 2, LVN 5, or CNA 2. Observed TN 2 used disposable cloths to clean the perineal area of Resident 21. Observed Resident 21 moaned with some facial grimacing throughout the care provided. Observed TN 2, LVN 5, and CNA 2 did not ask Resident 21 if the resident was having pain before or during indwelling catheter care. TN 2 then exited the area after completing the care and LVN 5 remained at bedside. The surveyor then asked Resident 21 if Resident 21 was having pain. LVN 5 stated Resident 21 speaks Armenian. LVN 5 stated the word for pain in Armenian to Resident 21 and Resident 21 responded yes. While in the hallway outside Resident 21's room, TN 2 stated TN 2 did not assess Resident 21's pain level before, during, or after providing catheter care. TN 2 stated Resident 21's skin looked red and painful, and TN 2 should have asked Resident 21 about pain but did not. Observed LVN 6 enter then exit Resident 21's room. LVN 6 stated LVN 6 was the medication nurse for Resident 21 and Resident 21 was complaining of pain. LVN 6 stated LVN 6 would administer pain medication to Resident 21. TN 2 stated it was important to address resident pain, so the resident did not have pain during the care. TN 2 stated when a resident has untreated pain it can result in a decreased quality of life for the resident. During an interview on 7/17/2025 at 11:09 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility did not have sufficient staff to provide Restorative Nursing Assistant ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) services to 244 residents, including Resident 159, on 7/15/2025. This deficient practice had the potential for the residents to develop limitations in range of motion ([ROM] full movement potential of a joint) and mobility (ability to move). Cross reference F842 Findings: During a review of the job description titled, Director of Clinical Services, revised 5/2011, the responsibilities of the Director of Clinical Services included to determine staffing needs and ensure scheduling was done accordingly. During a review of the RNA job description, revised 10/2011, the RNA job description indicated the Director of Clinical Services was the immediate supervisor. The RNA job description included providing restorative nursing care as directed and ordered, including feeding, active range of motion ([AROM] performance of ROM of a joint without any assistance or effort of another person), passive range of motion ([PROM] movement of a joint through the ROM with no effort from person), ambulation (the act of walking), and transfers. During a review of the facility census printed on 7/15/2025 at 7:08 a.m., the census indicated 244 residents resided in the facility. During a review of the RNA Assignment, dated 7/15/2025, the RNA Assignment indicated the facility had eight nursing stations and listed the corresponding beds in each nursing station. The RNA Assignment indicated six RNAs were scheduled to provide RNA services to the eight nursing stations. The RNA Assignment indicated RNA 1 and RNA 6 were each assigned one nursing station and divided the assignment of an additional nursing station. The RNA Assignment also indicated RNA 4 and RNA 9 were each assigned one nursing station and divided the assignment of additional nursing station. The RNA Assignment indicated RNA 1 had 43 residents, Resident 4 had 46 residents, RNA 5 had 44 residents, RNA 6 had 31 residents, RNA 9 had 47 residents, and RNA 10 had 33 residents for RNA services on 7/15/2025. During an interview on 7/15/2025 at 10:59 a.m. with the Director of Rehabilitation (DOR), the DOR stated the RNAs provided maintenance services including ROM, the application of splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion), sit-to-stand transfers, and ambulation. The DOR stated nursing unit referred residents to the RNA feeding program. During an interview on 7/16/2025 at 1:22 p.m. with RNA 2, RNA 2 stated she was responsible for the schedules and assignments of the RNA staff. RNA 2 stated eight RNAs scheduled per day was perfect, seven RNAs scheduled per day was okay, but six RNAs scheduled per day was tough to provide RNA services. RNA 2 stated six RNAs were scheduled on 7/15/2025 to provide RNA services to the eight nursing because some RNA staff had time off. RNA 2 stated additional RNAs were not contacted to cover the two nursing stations. RNA 2 stated RNA 1, RNA 4, RNA 6, and RNA 9 had residents added to their RNA assignments for 7/15/2025 to cover the two nursing stations. During an interview on 7/16/2025 at 1:25 p.m. with RNA 1 and RNA 6, RNA 1 and RNA 6 stated they were unable to provide RNA sessions to their assigned stations on 7/15/2025. RNA 1 stated Resident 159 did not receive RNA for ambulation since Resident 159 required the assistance of two people. RNA 1 stated there were no other available RNAs to assist with Resident 159. During an interview on 7/17/2025 at 11:15 a.m. with RNA 3, RNA 3 stated each of the eight nursing stations had one primary (main) RNA. RNA 3 stated there were five RNAs that floated to different nursing stations when the primary RNA was off. RNA 3 stated all residents admitted to the facility received RNA services. RNA 3 stated there was an RNA staffing shortage over the past two days, requiring assistance from the Activity Staff who were also Certified Nursing Assistants and RNAs to assist with the RNA feeding program for breakfast and lunch. During an observation on 7/17/2025 at 1:52 p.m. with RNA 1 and RNA 7, Resident 159 sat on a wheelchair in the hallway with a safety belt (assistive device placed around a person's waist to assist with safe transferring between surfaces or while walking) placed around Resident 159's waist. RNA 1 stood on Resident 159's left side while RNA 7 stood on the right side to physically assist Resident 159 to stand from the wheelchair. Resident 159 was observed in half standing position with the buttocks approximately eight inches above the wheelchair seat's surface. Resident 159 shuffled some steps forward but sat back down onto the wheelchair. RNA 1 and RNA 7 again physically assisted Resident 159 from sitting on the wheelchair to the half standing position. RNA 1 and RNA 7 held onto Resident 159's safety belt while RNA 1 pushed the FWW to encourage Resident 159 to shuffle both feet forward and RNA 7 pulled the wheelchair behind Resident 159. Resident 159 sat back down into the wheelchair. During an interview on 7/17/2025 at 2:01 p.m. with RNA 1 and RNA 7, RNA 1 stated Resident 159 required maximum assistance of two people to walk

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to perform competency skills evaluations (systematic process that evaluated an individual's skill and knowledge) for three of 13 Restorative Nursing Assistants ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility [ability to move]; RNA 4, RNA 5, and RNA 6) prior to providing RNA services, including the provision of feeding assistance, the provision of range of motion ([ROM] full movement potential of a joint) exercises, application of splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion), and the provision of ambulation (the act of walking). This deficient practice had the potential for 244 residents receiving RNA services to develop ROM limitations, decline in mobility, and aspiration (when food or liquid goes into the airway instead of the esophagus). Cross reference F684 and F688. Findings: During a review of the facility census, dated 7/14/2025 at 9:48 a.m., the census indicated 244 resided in the facility. During an interview on 7/15/2025 at 10:59 AM with the Director of Rehabilitation (DOR), the DOR stated the RNAs provided maintenance services including ROM, the application of splints, sit-to-stand transfers, and ambulation. The DOR stated nursing unit referred residents to the RNA feeding program. During an interview on 7/15/2025 at 10:13 a.m. with Restorative Nursing Assistant 4 (RNA 4), RNA 4 stated she has been an RNA for two months. During an interview on 7/16/2025 at 8:09 a.m. with Restorative Nursing Assistant 5 (RNA 5), RNA 5 stated she has been an RNA for approximately four mouths. During an interview on 7/16/2025 at 1:13 p.m. with Restorative Nursing Assistant 6 (RNA 6), RNA 6 stated she was a new RNA along with RNA 4 and RNA 5. During an interview on 7/17/2025 at 11:15 a.m. with RNA 3, RNA 3 stated each of the eight nursing stations had one primary (main) RNA. RNA 3 stated there were five RNAs that floated to different nursing stations when the primary RNA was off. RNA 3 stated all residents admitted to the facility received RNA services. During a concurrent observation and interview on 7/17/2025 at 11:14 a.m. with RNA 5, RNA 5 stated she was not working today but had to come in to work. RNA 5 had a competency form on the table. During a review of the Restorative Nursing Skills Evaluation form, the Restorative Nursing Skills Evaluation included but was not limited to placing the front wheeled walker ([FWW] an assistive device with two front wheels used for stability when walking) in front of the resident, supporting the resident during standing, coaching the resident during walking, passive range of motion ([PROM] movement of a joint through the ROM with no effort from person) exercises, active range of motion ([AROM] performance of ROM of a joint without any assistance or effort of another person) exercises, active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) exercises, splint assistance, and feeding techniques. During a concurrent interview and review of employee files on 7/17/2025 at 11:45 a.m. with the Director of Staff Development (DSD), RNA 4, RNA 5, and RNA 6's employee files were reviewed. The DSD did not have the dates RNA 4, RNA 5, and RNA 6 transitioned from Certified Nursing Assistants (CNAs) to RNAs. The DSD stated the new RNAs were coupled with an experienced RNA for orientation. The DSD stated the facility did not have any documented evidence RNA 4, RNA 5, and RNA 6 received a competency evaluation to provide RNA services after orientation. The DSD stated the facility accepted their skills based on their RNA certification (additional training in restorative care techniques). The DSD stated an outside contractor, Therapy Regional Manager (TRM), completed the Restorative Nursing Skills Evaluations once per year. RNA 4's employee file included an RNA certification, dated 3/10/2023, and RNA 4's Restorative Nursing Skills Evaluation was completed on 6/26/2025. RNA 6's employee file included an RNA certification, dated 3/10/2023, and RNA 6's Restorative Nursing Skills Evaluation was completed on 6/26/2025. RNA 5's employee file included an RNA certification, dated 12/2017, and did not include a Restorative Nursing Skills Evaluation. The DSD stated RNA 5 did not complete the annual Restorative Nursing Skills Evaluation on 6/26/2025 because RNA 5 had time off. The DSD stated TRM was supposed to but did not complete RNA 5's Restorative Nursing Skills Evaluation today (7/17/2025). During an interview on 7/17/2025 at 4:23 p.m. with the DSD, the DSD provided the facility's RNA schedule to determine the dates RNA 4, RNA 5, and RNA 6 began providing RNA services. The DSD stated RNA 4 started on 5/19/2025, RNA 5 started on 2/24/2025, and RNA 6 started on 5/19/2025. During an interview on 7/18/2025 at 9:46 a.m. with the TRM, the TRM stated RNA 5's Restorative Nursing Skills Evaluation was started but was not completed. The TRM stated the RNAs (in general) were observed while providing RNA services to determine their skills competencies. The TRM stated RNA 5 provided ambulation with a resident (unknown) and had to

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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 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. Based on interview and record review the facility failed to ensure sulfamethoxazole trimethoprim (antibiotic medication used to treat infection) was administered on 7/13/2025, at 9 a.m., per physician's order for one of five sampled residents (Resident 44). The facility also failed to reconcile (comparing medication activity to supporting documentation) six medication emergency kits (eKITs) for July 2025, in three of three medication rooms (Southwest Station, Southeast Station, East Station). These deficient practices had the potential for residents to experience medication errors, worsening of infection, and increased the opportunity for Controlled Medication diversion (CM - medications which have a potential for abuse, the transfer of a CM or other medication from a lawful to an unlawful channel of distribution or use). Findings:a.During a review of Resident 44’s admission Record, the admission Record indicated the facility admitted Resident 44 on 4/2/2025, with diagnoses including atherosclerotic heart disease (a condition where fatty deposits build up inside your arteries, making them narrow and stiff), generalized muscle weakness, and urinary tract infection (UTI- an infection in the bladder/urinary tract. During a review of Resident 44’s History & Physical (H&P) dated 4/3/2025, the H&P indicated Resident 44 did not have the capacity to understand and make decisions. During a review of Resident 44’s Minimum Data Set (MDS-a resident assessment tool), dated 4/9/2025, the MDS indicated Resident 44’s cognitive skills (ability to think, reason and use judgement) for daily decisions were moderately impaired and required maximum assistance from staff for toileting, showering and personal hygiene. During a review of Physician’s Order Audit Report dated 7/12/2025, the Order Audit Report indicated an order for Resident 44 to receive sulfamethoxazole-trimethoprim (antibiotic) tablet 800-160 milligrams (mg, unit of measurement) one tablet by mouth two times a day, for left thigh abscess (a localized collection of pus, usually caused by a bacterial infection, that forms within body tissue) for seven days. During a review of Resident 44’s Medication Administration Record (MAR) dated 7/2025, the MAR indicated Resident 44 did not receive the sulfamethoxazole-trimethoprim on 7/13/2025, at 9 a.m. During a concurrent interview, and record review on 7/15/2025, at 1:52 p.m. with the Risk Management Nurse (RMN), Resident 44’s MAR dated 7/2025 and Progress Notes dated 7/13/2025, were reviewed. The RMN stated Resident 44’s MAR dated 7/13/2025 timed at 9 a.m. indicated code five (5.), which means see progress notes. The RMN stated Resident 44’s Progress Notes, dated 7/13/2025, timed at 8:24 a.m., did not indicate if sulfamethoxazole-trimethoprim was administered to Resident 44. The RMN stated Licensed Vocational Nurse (LVN) 1 should have administered and documented that sulfamethoxazole-trimethoprim was administered to Resident 44 on 7/13/2025, at 9 a.m. following the physician’s order. The RMN stated if the medication was not documented it meant the medication was not administered. The RMN stated based on the MAR and Progress Notes, Resident 44 did not receive the complete dose of the ordered antibiotic. The RMN stated LVN 1 should have notified the physician if the medication was missed and get an order to continue if needed. The RMN stated Resident 44’s abscess would not be resolved because of the incomplete dose of antibiotic. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b.During an observation on 7/16/2025 at 11:10 a.m., with Licensed Vocational Nurse (LVN) 2, in Medication Room Southwest Station there was: -One medication eKIT stored in the refrigerator labeled “REF562” containing CMs without an accountability log for the reconciliation of the CM inventory at every shift change for July 2025. -One medication eKIT stored in the cabinet labeled “12” containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for July 2025. During a concurrent interview, LVN 2 stated that all CMs, including the medication eKITs containing CMs, should be reconciled at every shift. LVN 2 stated that the two eKITs labeled “12” and “REF562” containing CMs in Medication Room Southwest Station were not reconciled at every shift in July 2025, and it was important to account for all CMs to ensure accountability and prevent CM diversion. During an observation on 7/16/2025 at 11:21 a.m., with Registered Nurse (RN) 1, in Medication Room Southeast Station there was: -One medication eKIT stored in the refrigerator labeled “REF207” containing CMs without an accountability log for the reconciliation of the CM inventory at every shift change for July 2025. -One medication eKIT stored in the cabinet labeled “4” containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for July 2025. During a concurrent interview, RN 1 stated that all CMs should be reconciled at every shift. RN 2 stated the two eKITs labeled “4” and “REF207” containing CMs in Medication Room Southeast Station were not reconciled at every shift in July 2025, and it was important to account for all CMs to ensure accountability, prevent CM diversion, accidental exposure of harmful medications, and to prevent adverse effects to residents. During an observation on 7/16/2025 at 11:30 a.m., with LVN 3, in Medication Room East Station there was: -One medication eKIT stored in the refrigerator labeled “REF466” containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for July 2025. -One medication eKIT stored in the cabinet labeled “9” containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for July 2025. During a concurrent interview, LVN 3 stated that all CMs, including medication eKITs containing CMs, should be reconciled at every shift. LVN 3 stated that the two eKITs labeled “9” and “REF466” containing CMs in Medication Room East Station were not reconciled at every shift in July 2025. LVN 3 stated it was important to account for all CMs to ensure accountability, prevent CM diversion, and accidental exposure of harmful medications to residents. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/16/2025, at 2:55 p.m., the Assistant Director of Nursing (ADON) stated nurses should administer medication and document in the MAR per the physician’s order. The ADON stated an incomplete dose of antibiotic could result in an increase in Resident 44’s bacteria and white blood cells (part of the blood that’s its main job is to fight off infections and illnesses caused by things like viruses, bacteria, and other foreign invaders) and placed Resident 44 at a high risk for kidney damage. During an interview on 7/16/2025, at 4 p.m., the Director of Nursing (DON) stated nurses should medicate the resident according to the physician’s order and document in the residents MAR that the medication was administered. The DON stated a missed antibiotic dose could prolong Resident 44’s infection. During an interview on 7/18/2025 at 12:54 p.m., with the DON, ADON, and RMN, the ADON stated that medication eKITs containing CMs needed to be counted and reconciled at every shift change to ensure accountability and prevent CM diversion. The DON acknowledged per facility policy, reconciliation of CMs at each shift change should include eKITs containing CMs. The ADON stated six eKITs labeled “2, 4, 9, REF207, REF 466, REF562” containing CMs in Medication Room Southwest, Southeast and East stations did not have accountability and reconciliation logs at each shift change for July 2025. The DON stated not reconciling eKITs containing CMs can lead to accountability failures, and CM diversion. The ADON acknowledged the facility failed to follow policy and procedure of reconciling eKITs containing CMs. During a review of the facility’s Policy and Procedures (P&P) titled “Controlled Medication Storage,” last reviewed 4/28/2025, the P&P indicated “Medications included in the Drug Enforcement Administration classification as CSs are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. A. The DON and the Consultant Pharmacist maintain the facility’s compliance with federal and state laws and regulations in the handling of CMs. D. At each shift change, a physical inventory of all CMs, including the emergency supply, is conducted by two licensed nurses and is documented on the CM accountability record. I. The director of nursing in conjunction with the consultant pharmacist or designee routinely monitors CM storage, records, and expiration dates during medication storage inspection.” During a review of facility’s P&P titled, “Medication-Administration,” dated 7/1/2016, and last reviewed on 4/28/2025, the P&P indicated “Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner.” The Licensed Nurse will chart the drug, time administered and initial his/her name with each medication administration and sign full name and title on each page of the MAR. 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.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to act upon the recommendations of the consultant pharmacist for two of six sampled residents (Residents 27 and 19) reviewed for Unnecessary Medications, Psychotropic (medications capable of affecting the mind, emotions, and behavior) Medications, and Medication Regimen Review (MRR-a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) care area by: 1. Failing to follow-up with Resident 27's physician regarding the consultant pharmacist's MRR recommendation to add Eliquis (also known as apixaban - a type of blood thinner medication to prevent blood clots). This deficient practice had the potential to place Resident 27 at risk for ineffective treatment or adverse effects. 2. Failing to follow up with Resident 19's physician regarding the consultant pharmacist's MRR recommendation to indicate an end date for the continued use of Ativan (also known as lorazepam, a type of medication primarily used for short term treatment of anxiety disorders [a mental health condition where excessive fear and worry interfere with daily life, causing significant distress] and insomnia [difficulty sleeping]). This deficient practice had the potential to place Resident 19 at risk for development of adverse side effects from the continued use of the medication. Findings: a. During a review of Resident 27's admission Record, the admission Record indicated the facility admitted the resident on 8/1/2023 with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 27's History and Physical (H&P), dated 8/16/2024, the H&P indicated Resident 27 did not have the capacity to understand and make decisions. During a review of Resident 27's Minimum Data Set (MDS-a resident assessment tool), dated 4/1/2025, the MDS indicated Resident 27 had minimal difficulty hearing, sometimes had the ability to make self understood and understand others. The MDS indicated Resident 27 required substantial/maximal to total assistance from staff with all activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 27's Order Summary Report dated 7/18/2025, the Order Summary Report indicated the following physician's orders: -4/3/2024: Eliquis (apixaban) oral tablet 2.5 milligrams (mg - a unit of measurement) give 1 tablet by mouth 2 times a day related to atherosclerotic heart disease of native coronary artery without angina pectoris. -8/1/2023: Anticoagulant medication - monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status, shortness of breath, nose bleeds every shift. -7/9/2025: Anticoagulant medication/Eliquis - monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status, shortness of breath, nose bleeds every shift. During a review of Resident 27's care plan (CP) on risk for adverse reaction from Eliquis therapy initiated on 8/10/2023, the CP indicated to observe Resident 27 and report for any signs and symptoms of but not limited to bleeding gums, bruises on arms or legs, nose bleeds as one of the interventions so the resident will have no adverse reactions from the Eliquis therapy. During a review of Resident 27's Consultant Pharmacist's MRR created between 5/1/2025 and 5/4/2025, the Consultant Pharmacist's MRR indicated to add Eliquis to anticoagulant monitoring. During a concurrent interview and record review on 7/18/2025 11:44 AM, reviewed Resident 27's electronic health record, MRR created between 5/1/2025 and 5/4/2025, and medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 5/2025, 6/2025, and 7/2025 with the Risk Management Nurse (RMN). The RMN stated the MRR created between 5/1/2025 and 5/4/2025, indicated to add Eliquis to the anticoagulant monitoring. The RMN stated she was unable to find documented evidence that the pharmacist recommendation was addressed with the physician. The RMN stated the monthly pharmacist recommendations are delegated to the care planners and/or Registered Nurse (RN) supervisors to address with the physicians within 1 week. The RMN stated the care planners or RN supervisors assigned should have addressed the pharmacy recommendations with the physician timely. The RMN stated Eliquis was added to the anticoagulant monitoring on 7/9/2025. The RMN stated the pharmacist recommendation was not addressed timely. The MRN stated it is important to add the type of medicine that was being monitored so the staff would be aware which medication they are monitoring which could lead to unmonitored adverse

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (% - one per hundred). Two medication errors out of 26 total opportunities contributed to an overall medication error rate of 7.69 % affecting two of three residents observed for medication administration (Residents 215 and 106). The medication errors were as follows: 1.Resident 215 did not receive Senna Plus (a combination medication containing senna [a laxative] with docusate [a stool softener] used for constipation) as ordered by Resident 215's physician. Instead, Resident 215 received senna tablet. 2.Resident 106 was not instructed to rinse out mouth with water and spit after the administration of Symbicort (a corticosteroid [an anti-inflammatory medication also known as steroid] medication used for wheezing [difficulty in breathing]) inhalation, as ordered by Resident 106's physician and manufacturer guidelines. These failures had the potential to result in Residents 215 and 106 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in their health and well-being to be negatively impacted. Findings: During an observation on 7/15/2025 at 8:44 a.m., in Medication Cart Southwest Cart 1, with Licensed Vocational Nurse (LVN) 4, LVN 4 was observed administering senna 8.6 milligram ([mg]-a unit of measure of mass) tablet orally to Resident 215. Resident 215 was observed swallowing senna 8.6 mg tablet with a sip of water. During an interview on 7/15/2025 at 12:45 p.m., with LVN 4, LVN 4 stated during the morning medication administration at 8:44 a.m. LVN 4 administered senna 8.6 mg tablet to Resident 215. LVN 4 acknowledged the physician's order specified to administer Senna Plus to Resident 215. LVN 4 stated that LVN 4 failed to administer Senna Plus and instead administered senna which did not match the physician's order. LVN 4 stated Senna Plus includes a laxative and stool softener and not administering Senna Plus could potentially harm Resident 215 by increasing the risk of having hard stools and constipation. LVN 4 stated this was considered a medication error and that LVN 4 needed to report the error. During an observation on 7/15/2025 at 10:05 a.m., in Medication Cart Southwest Cart 2, with LVN 2, LVN 2 was observed administering Symbicort 2 puffs oral inhalation to Resident 106. Resident 106 was observed inhaling Symbicort 2 puffs. During an interview on 7/15/2025 at 12:50 p.m., with LVN 2, LVN 2 stated during the morning medication administration at 10:05 a.m. LVN 2 did not instruct Resident 106 to rinse mouth and spit after the two puffs oral inhalation of Symbicort. LVN 2 stated that LVN 2 failed to follow the physician and manufacturer guidelines to instruct Resident 106 to rinse out mouth with water and spit after administering Symbicort inhalation. LVN 2 stated not rinsing the mouth after administering Symbicort can cause medication to remain in the mouth harming Resident 106 by irritating the oral mucosa (membrane that lines the inside of the mouth) and resulting in oral thrush (a fungal infection of the mouth that causes creamy white lesions on the tongue, inner cheeks, and sometimes the roof of the mouth, throat, or gums, that can be painful and may bleed.) During an interview on 7/18/2025 at 12:54 p.m., with the Director of Nursing (DON,) and Assistant Director of Nursing (ADON), and in the presence of Risk Management Nurse (RMN), the ADON stated that LVN 4 failed to administer Senna Plus to Resident 215, according to Resident 215's physician order. The ADON stated that Resident 215 may be at risk for experiencing constipation, and hard stools by not receiving Senna Plus. The ADON stated that LVN 2 failed to administer Symbicort to Resident 106 according to physician orders and manufacturer guidelines. The ADON stated LVN 4 failed to instruct Resident 106 to rinse with water and spit after the inhalation of Symbicort placing Resident 106 at risk of developing oral thrush. The ADON stated that licensed nurses should follow facility medication administration guidelines to ensure physician orders are followed and the five/seven rights of medication administration are followed to ensure residents receive the correct medications according to physician orders and manufacturer guidelines. During a review of Resident 106's admission Record (a document containing demographic and diagnostic information,) dated 7/16/2025, the record indicated Resident 106 was originally admitted to the facility on [DATE] with diagnosis including chronic obstructive pulmonary disease ([COPD - a condition that makes it difficult to breathe.]) During a review of Resident 106's Order Summary Report, dated 7/16/2025, indicated Resident 106 was prescribed Symbicort 2 puffs to inhale orally twice a day related to COPD and rinse mouth with water after use, gargle and spit out, starting 4/9/2025. During a review of Resident 106's Medication Administration Record ([MAR] - a record of mediations administered to residents) for July 2025, the MAR indicated Resident 106 was prescribed Symbicort 2 puffs inhale orally twice a day related to COPD and rinse mouth with water after use

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure three of five sampled residents (Resident 6, Resident 106 and Resident 207) were free of significant medication errors. For Resident 6, the insulin administration sites were not rotated per standard of care. For Resident 106, the azithromycin (an antibiotic medication used to treat infections) was not administered timely, per physician's order on 7/16/2025, and Resident 207 received nine doses of expired fluticasone and salmeterol (a combination medication used to treat breathing disorders) inhalation powder Diskus (inhaler device used to deliver medication to the lungs). These deficient practices had the potential to cause Resident 6, 106 and 207 to experience significant adverse effects (unwanted, unintended results) and serious health complications, including tissue damage, difficulty breathing, and progression of infection. Cross Reference F658 and F761 Findings:a. During a review of Resident 6’s admission Record, the admission Record indicated the facility admitted the resident on 1/27/2017, with diagnoses including long term use of insulin, type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic chronic kidney disease (a kidney disease caused by diabetes), and hyperglycemia (high blood sugar). During a review of Resident 6’s History and Physical (H&P) dated 3/15/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 6’s Minimum Data Set (MDS, a resident assessment tool), dated 6/3/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and sometimes had the ability to understand others. The MDS indicated Resident 6 had severely impaired cognition (unable to think, remember or us judgement) and was on a high-risk drug class hypoglycemic medication (a group of drugs used to help reduce the amount of sugar present in the blood). During a review of the Physician’s Order Review History Report, the Order Review History Report indicated for Resident 6 was to receive: - 3/15/2025, Admelog SoloStar Subcutaneous Solution Pen-injector 100 unit per milliliters (unit/ml, the amount of insulin in a specific volume of liquid) (Insulin Lispro). Inject as per sliding scale (a customized guide, the amount of insulin to inject before meals or at specific times, based on their current blood sugar level), subcutaneously (under skin) before meals related to type 2 diabetes mellitus with hyperglycemia. Call physician if above 400 or below 70. -6/15/2025 Basaglar KwikPen Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine). Inject 60 units subcutaneously in the morning related to type 2 diabetes mellitus with hyperglycemia, before meals, breakfast. During a review of Resident 6’s Care Plan titled, “Diabetes Mellitus: At risk for hyper/hypoglycemia (low blood sugar) episodes,” initiated on 1/27/2017, the care plan indicated an intervention to administer Lispro insulin per sliding scale and Basaglar Kwik pen under skin in the morning as ordered. During a review of Resident 6’s Location of Administration Report of insulin for 5/4/2025 to 7/8/2025, the Location of Administration Report indicated that insulin: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Admelog Solostar Subcutaneous Solution Pen-injector 100 unit/ml was administered four times on 5/6 – 5/11/2025 to Resident 6’s Abdomen-Left Lower Quadrant (LLQ), and on 5/18 -5/19/2025 to LLQ. On 6/7, 6/8, 6/20 and 6/21/2025, the insulin was again administered to Resident 6’s LLQ. On the morning and afternoon on 7/8/2025 the insulin was administered to Resident 6’s RUQ. -Basaglar KwikPen Subcutaneous Solution Pen-injector 100 unit/ml was administered on 5/4, 5/5 and 5/6/2025 to Resident 6’s RLQ. On 5/7, 5/8, 5/11 and 5/12/2025 the insulin was administered to Resident 6’s the LLQ. On 5/17, 5/18, 5/21, 5/22/2025 the insulin was administered to Resident 6’s RLQ and on 6/20, and 6/21/2025 to the residents RLQ. During a concurrent interview and record review on 7/17/2025, at 3:59 p.m., with Licensed Vocational Nurse (LVN) 12, Resident 6’s Medical Diagnosis, Order Review History Report, Medication Administration Record (MAR), Location of Administration of insulin for 5/2025 to 7/2025, and Care Plan was reviewed. LVN 12 stated there were multiple instances where the licensed nurses did not rotate insulin administration sites to Resident 6. LVN 12 stated the licensed nurses should rotate sites of administration of insulin to prevent tissue damage such as lipodystrophy. LVN 12 stated injecting the insulin on the sites of lipodystrophy affects the absorption of the medication that can cause the resident to have hypo/hyperglycemia. LVN 12 stated not rotating insulin administration sites was a medication error. During an interview on 7/18/2025, at 10 a.m., Registered Nurse (RN) 4 stated the licensed staff should rotate insulin administration sites on Resident 6. RN 4 stated they rotate injection sites to prevent the tissues from hardening, lipodystrophy, and the absorption of insulin would not be effective, causing the residents to have a high blood sugar level. RN 4 stated they consider not rotating insulin administration sites as a medication error. During an interview on 7/18/2025, at 1:39 p.m., the Director of Nursing (DON) stated the licensed staff should have rotated the sites of insulin administration to Resident 6 to prevent infection, skin irritation, big purple areas on the skin, and lipodystrophy. The DON stated injecting insulin on the sites with lipodystrophy can predispose the resident to hypoglycemia (low blood sugar). The DON stated not rotating insulin administration sites was a medication error. b. During a review of Resident 106’s admission Record, the admission record indicated Resident 106 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease that makes it difficult to breathe). During a review of Resident 106’s chest x-ray, dated 7/14/2025, the report indicated Resident 106 had mild bronchitis (inflammation of the airways that carry air to and from the lungs) with infective etiology (referring to the cause of disease by bacteria, viruses, fungi, or parasites). During a review of the Physician’s Order Audit Report dated 7/16/2025, the audit report indicated on 7/14/2025 at 11:44 p.m. Resident 106’s physician prescribed azithromycin 250 mg, two tablets, one time only for infection for one day, and give one tablet once a day for infection for four days starting on day two. During a review of Resident 106’s azithromycin Order Details, the document indicated: -Order date 7/14/2025 11:44 p.m. (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Azithromycin 250 mg tablet, two tablets for infection starting 7/15/2025 at 9 a.m. -Azithromycin 250 mg tablet orally, one tablet for infection starting 7/17/2025 at 9 a.m. for four days. During a review of Resident 106’s Medication Administration Record (MAR) for July 2025, the MAR indicated Resident 106 was prescribed: -Azithromycin 250 mg tablet, two tablets one time only for infection for one day, starting on 7/15/2025, and -Azithromycin 250 mg tablet, one tablet once a day for infection for four days starting on day two, scheduled for 9 a.m. on 7/17, 7/18, 7/19, and 7/20/2025. The MAR indicated there was no Azithromycin 250 mg dose scheduled for day two on 7/16/2025. During an interview on 7/16/2025 at 10 a.m., the Assistant Director of Nursing (ADON) stated the ADON failed to correctly transcribe (converting spoken words into written text) the azithromycin order for Resident 106 in the July 2025 MAR, erroneously starting the second dose on 7/17/2025 at 9 a.m. and omitting the physician’s order to start the second dose on day two on 7/16/2025. The ADON stated the ADON would contact the physician to obtain a one-time order for 7/16/2025 since the dose should have been administered at 9 a.m. and was now considered late. During an interview on 7/18/2025 at 12:55 p.m., the ADON and DON stated it was important to administer full antibiotic therapy as ordered by the physician to effectively treat infections and prevent worsening of infections. The ADON stated the inaccurate transcription of the azithromycin order for Resident 106 by the ADON, led to omitting a dose on the MAR on day two (7/16/2025) and starting the second dose on 7/17/2025. The ADON stated the dose was administered late on 7/16/2025 and that omitting a dose of antibiotic or administering late was considered a significant medication error as Resident 106 was at risk of worsening lung infection by not being treated timely. c. During a review of Resident 207’s admission Record, the admission Record indicated Resident 207 was admitted to the facility on [DATE] with diagnoses including COPD. During a review of the Physician’s Order Summary dated 7/16/2025, the summary indicated Resident 207 was prescribed Advair Diskus (brand name for fluticasone and formoterol,) 250-50 microgram per dose, one puff inhale orally twice a day related to COPD, starting 10/2/2024. During a review of Resident 207’s MAR for July 2025, the MAR indicated Resident 207 was prescribed Advair Diskus 250-50 microgram per dose one puff to be inhaled orally twice a day related to COPD, at 9 a.m. and 5 p.m., and that Resident 207 received nine doses of fluticasone and formoterol from the following nurses on the following dates and times: LVN 3 – five doses at 9 a.m. on 7/12, 7/13, 7/14, 7/15, and 7/16/2025. LVN 9 – two doses at 5 p.m. on 7/14 and 7/15/2025. LVN 10 – one dose at 5 p.m. on 7/13/2025. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 11 – one dose at 5 p.m. on 7/12/2025. During an observation on 7/16/2025 at 11:37 am, in East Station Medication Cart 1, in the presence of LVN 3, one open fluticasone and salmeterol inhalation powder Diskus (for Resident 207) was found stored at room temperature and marked with a black marker indicating storage began on 6/11/2025. During a concurrent interview, LVN 3 stated the fluticasone and salmeterol inhalation powder Diskus for Resident 207 was stored in the medication cart and opened on 6/11/2025. LVN 3 stated according to the manufacturer guidelines printed on the carton box containing the fluticasone and salmeterol inhalation powder Diskus, to store the inhaler at room temperature and discard the inhaler one month after opening the foil pouch or when the counter (on the Diskus) reads “0”, whichever comes first. LVN 3 stated the inhalation powder expired on 7/11/2025 and needed to be removed the medication cart to prevent an administration error. LVN 3 stated expired fluticasone and salmeterol inhalation powder had lost potency and would not be effective in treating the COPD, potentially causing harm to resident 207, exacerbating (making worse) difficulty in breathing. LVN 3 stated several licensed nurses failed to remove the expired fluticasone and salmeterol inhalation powder Diskus from the medication cart and as a result, several licensed nurses, including LVN 3, administered nine doses of expired fluticasone and salmeterol inhalation powder to Resident 207 between 7/12/2025 and 7/16/2025. During a review of the manufacturer’s product storage and labeling sheet, the sheet indicated fluticasone and salmeterol inhalation powder should be stored at room temperature and discarded one month after removal from the foil overlap packaging pouch. During an interview on 7/18/2025 at 12:54 p.m., with the DON and ADON, and in the presence of Risk Management Nurse (RMN), the ADON stated fluticasone and salmeterol inhalation powder Diskus for Resident 207 expired on 7/11/2025. The ADON and DON stated expired medications need to be removed from use to prevent accidental use. The ADON and DON stated that expired inhalers have lost effectiveness and strength, and when administered would not treat the COPD, further causing respiratory distress and exacerbation or shortness of breath. The DON stated several licensed nurses failed to remove the expired Diskus from East Station Medication Cart 1 leading to the administration of nine doses of expired medications fluticasone and salmeterol, which were considered significant medication errors. During a review of the facility’s policy and procedures (P&P) titled, “Medication Errors,” last reviewed 4/28/2025, the P&P indicated “to ensure the prompt reporting of errors in the administration of medications and treatments to residents. I.Definition – the preparation or administration of medications or biologicals which is not in accordance with: a. The prescriber’s order b. Manufacturer’s specifications regarding the preparation and administration of the medication or biological. c. Accepted professional standards and principles which apply to professionals providing services. d. A medication error may be the administration or omission of medication: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ii. At the wrong time.” During a review of the facility’s P&P titled, “Discontinued Medications,” last reviewed 4/28/2025, the P&P indicated when medication are expired, the medications are marked as “discontinued” or stored in a separate location and later destroyed. A.If a medication expires, the discontinued drug container shall be marked or otherwise identified or shall be stored in a separate location designated solely for this purpose. B.Medications awaiting disposal or return are stored in a locked secure area designated for that purpose until destroyed or picked up by pharmacy. Medications are removed from the medication cart or storage area prior to expiration. During a review of facility’s P&P titled, “Storage of Medications,” last reviewed 4/28/2025, the P&P indicated “Medications and biologicals ae stored safely, and properly, following manufacturer’s recommendations or those of the supplier. -M. Outdated, contaminated, or deteriorated medications are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. During a review of manufacturer’s guidelines titled, “Highlights of Prescribing Information, ” for Advair Diskus, last revised April 2008, the document indicated “The Diskus should be discarded one month after removal from the moisture-protective foil overwrap pouch or when the dose indicator reads 0, whichever comes first. Safely discard ADVAIR DISKUS one month after you remove it from the foil pouch, or after the dose indicator reads 0, whichever comes first.” During a review of facility’s P&P titled, “Guide for Special Handling of Medications,” last reviewed 4/28/2025, the guide indicated “Advair Diskus (fluticasone/formoterol) – Date the Diskus when removed from the foil pouch and discard one month after removal from foil pouch or when the dose counter reads 0, whichever comes first.” During a review of the facility's P&P titled, Subcutaneous Injection/Insulin or Heparin, last reviewed on 4/28/2025, the P&P indicated injection sites will be rotated to avoid unnecessary trauma to tissues and aid in medication absorption. Hardened or painful areas will not be used for injection. To establish more consistent blood insulin levels, rotate insulin injection sites within anatomic regions. Preferred insulin injection sites are the arms, abdomen, thighs, and buttocks. During a review of the facility-provided Highlights of Prescribing Information on the use of Admelog (insulin lispro) injection, for subcutaneous or intravenous use, with initial U.S. approval in 2017, the Highlights of Prescribing Information indicated to administer ADMELOG by subcutaneous injection into the abdominal wall, thigh, upper arm, or buttocks within 15 minutes before a meal or immediately after a meal. Rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility-provided Highlights of Prescribing Information on the use of Basaglar (insulin glargine) injection, for subcutaneous use, with initial U.S. approval in 2015, the Highlights of prescribing Information indicated to rotate injection sites into the abdominal area, thigh, or deltoid to reduce the risk of lipodystrophy and localized cutaneous amyloidosis.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe provision of pharmaceutical services by failing: a. To ensure there were no expired hand sanitizer on the resident's bedside table for one of two sampled residents (Resident 72) observed during resident screening. The expiration date of the hand sanitizer is 3/2021. This deficient practice had the potential for Resident 72 to use an alcohol-based hand sanitizer past its efficacy state decreasing the effect of killing bacteria or viruses on the resident's hands that can lead to resident illnesses. b. To remove and discard from use from one of six inspected medication carts (East Station Medication Cart 1) one expired fluticasone and salmeterol (a combination medication used to treat chronic obstructive pulmonary disease [COPD - a condition that makes it difficult to breathe]) inhalation (form of medication that is inhaled) powder Diskus (inhaler device used to deliver medication to the lungs), belonging to Resident 207, observed during medication storage and labeling facility task, in accordance with facility policy and procedures and manufacturer's requirements. This deficient practice resulted in Resident 207 receiving medication that had compromised (decreased) efficacy and potency (strength of a medication,) and not effectively treating Resident 207's COPD, increasing the risk of health complications such as difficulty in breathing, and potentially resulting in hospitalization or death. Findings: a. During a review of Resident 72’s admission Record, the admission Record indicated the facility admitted the resident on 1/6/2023, with diagnoses including urinary tract infection (UTI, an infection in the bladder/urinary tract), Escherichia coli (e. coli, is a common type of bacteria that usually lives harmlessly in the intestines of humans and animals), and dementia (a progressive state of decline in mental abilities). During a review of Resident 72’s History and Physical (H&P), dated 1/1/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 72’s Minimum Data Set, dated [DATE], the MDS indicated the resident had the ability to make self understood and understand others and had intact cognition (means having the mental abilities like thinking, remembering, and learning functioning effectively to handle the normal demands of daily life). The MDS indicated Resident 72 required substantial to supervision assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 72 had occasional urinary incontinence (the loss of bladder control). During a review of Resident 72’s Order Review History Report, dated 1/6/2023, the Order Review History Report indicated an order for Resident 72 to be free from a communicable disease (an illness that can be spread from one person or animal to another, or even from contaminated surfaces or objects to a person). During a review of Resident 72’s Care Plan (CP) Report titled “At Risk for fall secondary to repeated falls/antihypertensive medication (are medicines used to treat high blood pressure, also known as hypertension),” initiated on 1/9/2024, the CP indicated an intervention to keep environment free of hazards such has wet spots and keep the pathway free from clutter. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/14/2025, at 2:28 p.m., with Licensed Vocational Nurse (LVN) 7, inside Resident 72’s room, observed Resident 72 had 2 hand sanitizers on the bedside table of the resident located on the foot part of the bed, one of the hand sanitizers had an expiration date of 3/2021. LVN 7 stated the hand sanitizers should not be left at the bedside of the resident because the resident can ingest them and cause an adverse reaction (a harmful or unwanted effect that happens when a person take a medication, vaccine, or are exposed to some other substance, even when they are using it correctly) to the resident and it should have been discarded. LVN 7 stated the expired hand sanitizer will not be able to effectively disinfect the hand of the resident that can cause cross-contamination (when harmful bacteria or other microorganisms are unintentionally transferred from one substance or surface to another, potentially causing illness) and infection to Resident 72. During an interview on 7/18/2025, at 10 a.m., with Registered Nurse (RN) 4, RN 4 stated all staff were not supposed to leave hand sanitizers inside the Resident 72’s room. RN 4 stated when the staff are doing their environment of safety rounds, they should remove all the hazards identified on the resident’s surroundings including expired sanitizing agents to prevent accidental ingestion of the sanitizers that can cause adverse effects of the residents. The expired alcohol-based hand sanitizer should be discarded per facility protocol. During an interview on 7/18/2025, at 1:39 p.m., with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the ADON stated the alcohol-based hand sanitizer should not be left at the bed side of Resident 72. The ADON stated that an alcohol-based hand sanitizer is a chemical and should be away from the residents due to potential accidental ingestion that can cause the resident to get ill. The ADON stated utilizing expired alcohol-based hand sanitizer will not be effective in sanitizing the hands of the staff and the residents that can predispose them to developing infection. During a review of the facility's policy and procedure (P&P) titled, Pharmacy Services Committee-Composition & Duties, last reviewed on 4/28/2025, the P&P indicated the Facility has a Pharmacy Services Committee (PSC) to oversee pharmacy services in the delivery of resident care at the facility. II. Duties and Responsibilities may consist of, but are not limited to the following: A. Development and review of policies and procedure for: i. Safe procurement, storage, distribution, use and disposal of drugs and biological. b. During an observation on 7/16/2025 at 11:37 am, in East Station Medication Cart 1, in the presence of Licensed Vocational Nurse (LVN) 3, the following medication was found either stored in a manner contrary to facility policies and manufacturer’s requirements, and expired and not discarded: One (1) open fluticasone and salmeterol inhalation powder Diskus for Resident 207 was found stored at room temperature and marked with a black marker indicating storage or use at room temperature began on 6/11/2025. According to the manufacturer’s product storage and labeling, fluticasone and salmeterol inhalation powder should be stored at room temperature between 68 and 77 degrees Fahrenheit and discarded one (1) month after removal from the foil (package made of foil protecting the inhalation powder from light and degradation) overlap (layer on the outside of the inhalation powder) pouch. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with LVN 3, LVN 3 stated that the fluticasone and salmeterol inhalation powder Diskus for Resident 207 was stored in the medication cart and opened on 6/11/2025. LVN 3 stated according to the manufacturer guidelines printed on the carton box containing the fluticasone and salmeterol inhalation powder Diskus, to store the inhaler at 68 and 77 degrees Fahrenheit and discard the inhaler one (1) month after opening the foil pouch or when the counter (on the Diskus) reads “0”, whichever comes first. LVN 3 stated the inhalation powder expired on 7/11 and needed to be removed the medication cart to prevent usage in error. LVN 3 stated expired fluticasone and salmeterol inhalation powder has lost potency and will not be effective in treating the COPD potentially causing harm to resident 207 exacerbating (making worse) the wheezing associated with COPD leading to difficulty in breathing and resulting in potential hospitalization. LVN 3 stated several licensed nurses failed to remove expired fluticasone and salmeterol inhalation powder Diskus from the medication cart and as a result, several licensed nurses including LVN 3 administered nine (9) doses of expired fluticasone and salmeterol inhalation powder to Resident 207 between 7/12/2025 and 7/16/2025. During an interview on 7/18/2025 at 12:54 p.m., with the Director of Nursing (DON,) and Assistant Director of Nursing (ADON), and in the presence of Risk Management Nurse (RMN), the ADON stated fluticasone and salmeterol inhalation powder Diskus for Resident 207 expired on 7/11/2025. The ADON and DON stated expired medications needed to be removed from use to prevent accidental use. The ADON and DON stated that expired inhalers have lost effectiveness and strength, and when administered will not treat the COPD further causing respiratory (related to breathing) distress and exacerbation, shortness of breath, and stoppage of breathing, resulting in needing to contact the physician and potentially transferring Resident 207 to the hospital. The DON stated that several licensed nurses failed to remove expired Diskus from East Station Medication Cart 1 leading to the administration of nine (9) doses of expired medications fluticasone and salmeterol, which were considered significant medication errors. During a review of the facility’s policy and procedures (P&P), titled “Discontinued Medications, ” last reviewed 4/28/2025, the P&P indicated: “When medications are expired, …the medications are marked as “discontinued” or stored in a separate location and later destroyed. A. If a medication expires…, the discontinued drug container shall be marked or otherwise identified or shall be stored in a separate location designated solely for this purpose. B. Medications awaiting disposal or return are stored in a locked secure area designated for that purpose until destroyed or picked up by pharmacy. Medications are removed from the medication cart or storage area prior to expiration….” During a review of facility’s P&P titled, “Storage of Medications,” last reviewed 4/28/2025, the P&P indicated: “Medications and biologicals ae stored safely, and properly, following manufacturer’s recommendations or those of the supplier. M. Outdated, contaminated, or deteriorated medications…are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists.” (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of manufacturer’s guidelines titled “Highlights of Prescribing Information” for Advair Diskus ((brand name for fluticasone and formoterol,) last revised April 2008, the document indicated: “The Diskus should be discarded 1 month after removal from the moisture-protective foil overwrap pouch or when the dose indicator reads “0”, whichever comes first. Safely discard ADVAIR DISKUS 1 month after you remove it from the foil pouch, or after the dose indicator reads “0”, whichever comes first.” During a review of facility’s P&P, titled “Guide for Special Handling of Medications,” last reviewed 4/28/2025, the guide listed the following: “Advair Diskus (fluticasone/formoterol) – Date the Diskus when removed from the foil pouch and discard 1 month after removal from foil pouch or when the dose counter reads “0”, whichever comes first.”

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen, reviewed during the Kitchen task by failing to: 1.Ensure food items in Walk-in Refrigerator 1 were labeled per facility policy. 2.Ensure food items in Walk-in Refrigerator 1, were properly covered with tight sealed lids per facility policy. 3.Ensure expired food items in Walk-in Refrigerator 1 and in the food preparation area were discarded per facility policy. 4.Ensure the sanitization buckets were maintained per the manufacturer guidelines with the recommended concentration level of chemicals. These deficient practices had the potential to result in harmful bacterial growth and cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs) in 240 of 241 medically compromised residents who received food and ice from the kitchen. Findings: a.During an Initial Kitchen Tour on 7/14/2025 at 9:55 a.m., with the Dietary Supervisor (DS), observed Walk-in Refrigerator 1 and the food preparation area. The DS stated the facility uses the First-In, First-Out method to ensure no expired or old food is served to residents. The DS stated all food items are labeled to indicate the date received, the date opened, and the use by or expiration date. The DS stated food is used or discarded by a date determined by the Food Storage Guidelines. The DS stated some foods are used within three days of opening and other foods, like vegetables, are used within seven days. The DS noted the following in Walk-in Refrigerator 1 and food preparation area: 1.In Walk-In Refrigerator 1: a.Observed a grey bin of apples labeled Product [NAME] (Apple), Date 5/4/25, Use By 5/15,. The DS stated apples are stored for two weeks and the label on the bin must be wrong. The DS stated staff should have labeled the bin when the new shipment of apples arrived, but they did not. The DS stated the apples were mislabeled and should not be stored and served to residents if the apples were received on 5/4/2025. The DS stated the DS cannot be sure when the apples in the bin were received because the bin is mislabeled. b.Observed a bag containing three heads of lettuce labeled with a received date of 7/2/2025. The DS stated lettuce is good for seven days after receipt. The DS stated the lettuce was not discarded or used within 7 days of receipt and the facility guidelines were not followed. Observed the DS removed the bag of lettuce from the refrigerator. c.Observed a box of sealed individually packaged sliced smoked ham labeled with a received by date of 5/28/25. The DS stated the box with sealed bags was removed from the freezer and the ham was partially thawed. The DS stated the facility process when removing food items from the freezer, is to label with the date removed from the freezer and indicate a use by date. The DS stated it was important to label items removed from the freezer because the use by date changes when the item is no longer frozen. The DS stated the packages of smoked ham should be used within three days after removal from the freezer. The DS stated the kitchen staff forgot to label the box when it was removed from the freezer. d.Observed a large, opened container of yogurt with the lid resting on top of the container and slightly pushed to the side exposing the yogurt inside. The DS stated the lid on the yogurt was not attached to the container, but it should have been to ensure that nothing falls inside and contaminates the yogurt. 2.In the Food Prep area: a.Observed a clear plastic bin with two pieces of sliced bread labeled with an open date of 7/10/2025 and a use by date of 7/13/2025. The DS stated the bread should have been removed and discarded from the prep area on 7/13/2025 and it was not. The DS stated it was important to remove the bread to ensure expired food was not served to residents. The DS stated the facility staff did not follow the facility process. During a follow up interview and record review on 7/18/2025 at 12:32 a.m. with the DS, the DS reviewed the facility policy and procedures (P&P) and guidelines regarding food storage and noted the following: a.Smoked ham deli meat should be used or discarded within five days of being thawed. The DS stated when the box of smoked ham was not immediately labeled when it was removed from the freezer, the staff did not follow the facility P&P. b.Lettuce should be used or discarded within five days. The DS stated the staff did not follow the P&P when the lettuce was stored in the refrigerator past five days. c.Apples should be used or discarded after two weeks when stored in the refrigerator. The DS stated staff did not follow the facility P&P when the bin of apples was stored in the refrigerator with a label indicating to discard 5/14/2025. The DS further stated the facility did not have a policy to ensure lids are tightly attached to containers, but it was a standard of practice to ensure that nothing enters the container and is then served to residents. The DS stated nonedible items could fall into the food and become a

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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 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 observation, interview, and record review, the facility failed to maintain complete and accurate medical record in accordance with accepted professional standards for 11 of 75 sampled residents, including five of five sampled residents (Residents 44, 106, 117,188, and 96) reviewed for infection control, 6 of 244 sampled residents (Resident 48, 121, 140, 146, 159, and 240) receiving Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) services, by failing to: 1. Ensure the Coronavirus Disease 2019 (COVID-19, respiratory illness and is spread through respiratory droplets) screening form and informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for COVID-19, influenza (a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and sometimes the lungs) and pneumococcal (disease is caused by bacteria) vaccinations (the administration of a vaccine to help the immune system develop immunity from a disease) were completed prior to Residents 44, 106, 117, 188, and 96 signing and acknowledging the form. 2. Document Resident 159's actual ability to perform ambulation (the act of walking) in the RNA Weekly Progress notes, dated 6/20/2025, 6/24/2025, 6/27/2025, 7/4/2025, 7/11/2025. 3. Document Resident 159's missed RNA treatment on 7/15/2025 and 7/16/2025. 4. Document Resident 240's inability to participate in sit-to-stand transfers with RNA on 7/14/2025. 5. Document Resident 48, 121, 140, and 146's missed RNA treatment on 7/15/2025. These failures had the potential to result in confusion in the care and services rendered to residents and resulted in incomplete information entered in Residents 44, 106, 117, 188, and 96's medical record. These failures also resulted in inaccurate medical records for Resident 48, 121, 140, 146, 159, and 240 which could potentially cause an undetected decline in ROM and mobility. Findings: a. During a review of Resident 44’s admission Record, the admission Record indicated the facility admitted Resident 44 on 4/2/2025, with diagnoses including atherosclerotic heart disease (a condition where fatty deposits build up inside your arteries, making them narrow and stiff), generalized muscle weakness and urinary tract infection (UTI-an infection in the bladder/urinary tract). During a review of Resident 44’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 4/3/2025, the H&P indicated Resident 44 did not have the capacity to understand and make decisions. During a review of Resident 44’s Minimum Data Set (MDS-a resident assessment tool), dated 4/9/2025, the MDS indicated Resident 44’s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. During a concurrent interview, and record review on 7/16/2025, at 8:13 a.m., with Registered Nurse 1 (RN 1), Resident 44’s COVID Screening Form dated 4/3/2025, did not indicate Resident 44’s temperature. RN 1 stated COVID Screening Form should indicate the resident’s temperature at the time the screening was performed. RN 1 stated if the resident’s temperature was not documented, then the screening form was not properly completed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 106’s admission Record, the admission Record indicated the facility admitted Resident 106 on 4/8/2025, with diagnoses including Parkinson’s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia (a progressive state of decline in mental abilities) and generalized muscle weakness. During a review of Resident 106’s H&P, dated 4/9/2025, the H&P indicated Resident 106 had fluctuating capacity to understand and make decisions. During a review of Resident 106’s MDS, dated [DATE], the MDS indicated Resident 106’s cognitive skills for daily decisions were moderately impaired. During a concurrent interview, and record review on 7/16/2025, at 8:13 a.m., with RN 1, Resident 106’s Influenza Vaccination Informed Consent/Refusal dated 4/8/2025, Pneumococcal Vaccination Informed Consent/Refusal dated 4/8/2025 and the COVID-19 Vaccination Informed Consent/Refusal dated 4/8/2025 were reviewed. RN 1 stated all three Vaccination Informed Consent did not indicate the name of the representative and the relationship of the representative to the resident. RN 1 stated the informed consent should be fully and properly filled out. During a review of Resident 117’s admission Record, the admission Record indicated the facility admitted Resident 117 on 5/29/2025, with diagnoses including metabolic encephalopathy (a change in how your brain works due to an underlying condition), unspecified (unconfirmed) dementia and generalized muscle weakness. During a review of Resident 117’s H&P, dated 6/6/2025, the H&P indicated Resident 117 had fluctuating capacity to understand and make decisions. During a review of Resident 117’s MDS, dated [DATE], the MDS indicated Resident 117’s cognitive skills for daily decisions were severely impaired. During a concurrent interview, and record review on 7/16/2025, at 8:13 a.m., with RN 1), Resident 117’s COVID Screening Form dated 4/3/2025 did not indicate Resident 117’s temperature. RN 1 stated the COVID Screening Form should indicate the resident’s temperature at the time the screening was performed. RN 1 stated if the resident’s temperature was not documented, then the screening form was not properly completed. During a review of Resident 188’s admission Record, the admission Record indicated the facility initially admitted Resident 188 on 12/4/2024, and readmitted on [DATE], with diagnoses including atherosclerotic heart disease, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and benign prostatic hyperplasia (BPH-a common condition in older men where the prostate gland grows larger than normal) with lower UTI. During a review of Resident 188’s H&P, dated 2/6/2025, the H&P indicated Resident 188 had fluctuating capacity to understand and make decisions. During a review of Resident 188’s MDS, dated [DATE], the MDS indicated Resident 188’s cognitive skills for daily decisions were moderately impaired. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, and record review on 7/16/2025, at 8:13 a.m., with RN 1, Resident 188’s COVID Screening Form dated 2/5/2025, Influenza Vaccination Informed Consent/Refusal dated 2/5/2025, and the COVID-19 Vaccination Informed Consent/Refusal dated 2/5/2025, were reviewed. RN 1 stated Resident 188’s COVID Screening Form did not indicate Resident 188’s temperature. RN 1 stated the COVID Screening Form should indicate the resident’s temperature at the time the screening was performed. RN 1 stated if the resident’s temperature was not documented, then the screening form was not properly completed. RN 1 stated Resident 188’s Influenza Vaccination Informed Consent/Refusal and the COVID-19 Vaccination Informed Consent/Refusal forms did not indicate the name of representative and relationship of the representative to the resident. RN 1 stated informed consents should be fully and properly filled out. During a record review of Resident 96’s admission Record, the admission record indicated the facility admitted Resident 96 on 5/16/2025 with diagnoses including Alzheimer’s Disease (a disease characterized by a progressive decline in mental abilities), dementia and generalized muscle weakness. During a review of Resident 96’s H&P, dated 5/19/2025, the H&P indicated Resident 96 did not have the capacity to understand and make decisions. During a review of Resident 96’s MDS, dated [DATE], the MDS indicated Resident 96’s cognitive skills for daily decisions were severely impaired. During a concurrent interview, and record review on 7/16/2025, at 8:13 a.m., with RN 1, Resident 96’s COVID Screening Form dated 5/16/2025, COVID-19 Vaccination Informed Consent/Refusal dated 5/16/2025, Influenza Vaccination Informed Consent/Refusal dated 5/16/2025, and the Pneumococcal Vaccination Informed Consent/Refusal dated 5/16/2025, were reviewed. RN 1 stated Resident 96’s COVID Screening Form did not indicate Resident 96’s temperature. RN 1 stated the COVID Screening Form should indicate the resident’s temperature at the time the screening was performed. RN 1 stated if the resident’s temperature was not documented, then the screening form was not properly completed. RN 1 stated Resident 96’s COVID-19 Vaccination Informed Consent/Refusal, Pneumococcal Polysaccharide and Influenza Vaccination Informed Consent/Refusal form did not indicate the last name of the resident’s representative. RN 1 stated Resident 96’s Influenza Vaccination Informed Consent/Refusal did not indicate the name of Resident 96. RN 1 stated the informed consents should be fully and properly filled out including the name and last name of the resident and the resident’s representative and the representative’s relationship to the resident. During an interview on 7/16/2025, at 2: 55 p.m., with the Assistant Director of Nursing (ADON), the ADON stated residents’ consent should be completely filled out including the name of the resident and their representative. The ADON stated a completed consent form ensures the appropriate representative provided consent for the vaccination. The ADON stated an incomplete consent form constitutes an incomplete resident medical record. During an interview on 7/16/2025, at 4 p.m., with the Director of Nursing (DON), the DON stated the Medical Records department should have audited the consents to ensure they were completely filled out. The DON stated the informed consents should be fully and properly filled out including the name and last name of the resident and the resident’s representative and the representative’s relationship to the resident. The DON stated a consent is a legal paper and if it is incomplete, it means it is an incomplete medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility’s policy and procedure (P&P), titled “Documentation-Nursing” dated 1/1/2016, and last reviewed on 4/28/2025, the P&P indicated “Nursing documentation will be concise, clear, pertinent, and accurate.” During a review of facility’s P&P, titled “Informed Consent” dated 4/1/2024, and last reviewed on 4/28/2025, the P&P indicated, “To ensure that the Facility respects the resident’s right to make an informed decision prior to deciding to undergo certain medical therapies and procedures. The informed consent must be signed by the resident or the resident's representative and the physician/LHP who provided the material information.” During a review of facility’s P&P, titled “COVID-19 Vaccination” dated 5/19/2025, was reviewed. The P&P indicated, “Prior to administering the vaccination, a nursing staff member will complete COVID-19 Vaccine – Resident Consent/Refusal with the resident or the resident’s representative. The resident or resident’s representative must sign the consent form prior to vaccine administration.” b. During a review of Resident 159’s admission Record, the admission Record indicated the facility admitted Resident 159 on 12/16/2023 with diagnoses including Alzheimer’s disease (disease characterized by a progressive decline in mental abilities), dementia (progressive state of decline in mental abilities), dysphagia (difficulty swallowing), aphasia (disorder that makes it difficult to speak), and obesity (high amount of body fat). During a review of Resident 159’s physician’s orders, dated 2/22/2024, the physician’s orders indicated to provide ambulation with assistance daily as tolerated and passive range of motion ([PROM] movement of a joint through the ROM with no effort from person) to both legs as tolerated. Another physician’s order, dated 2/24/2024, indicated active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) to both arms as tolerated. During a review of Resident 159’s care plan titled, “Ambulation with Assistance Due to Unsteady Gait and Balance/PROM Exercises to Lower Extremities (legs)/AAROM Exercises to Upper Extremities (arms) due to Limitations of Shoulders, Hips, and Knees,” initiated on 2/12/2025, the care plan interventions included to assist Resident 159 with ambulation with minimal assistance (requires less than 25 percent [%] physical assistance to perform the task) using the front wheeled walker ([FWW] an assistive device with two front wheels used for stability when walking) and safety belt (assistive device placed around a person’s waist to assist with safe transferring between surfaces or while walking) for 150 to 200 feet (unit of measure) daily as tolerated. Another intervention included performing AAROM to both of Resident 159’s arms and legs for eight to ten (8-10) repetitions daily as tolerated. During a review of Resident 159’s Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 5/11/2025, the MDS indicated Resident 159 did not have any speech, rarely/never expressed ideas and wants, did not understand verbal content, and was severely impaired for daily decision making. The MDS also indicated Resident 159 required partial/moderate assistance (helper does less than half the effort) for sit-to-stand transfers, chair/bed-to chair transfers, toilet transfers, and walking 160 feet. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a review of Resident 159’s Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment, dated 6/13/2025, the PT Evaluation indicated Resident 159 was referred to PT services from RNA due to Resident 159’s decreased activity tolerance, poor balance, difficulty with ROM exercises to both arms and legs, and difficulty with ambulation. The PT Evaluation indicated Resident 159 had within functional limits ([WFL] sufficient joint movement without significant limitation) ROM in both legs and required maximum assistance (required between 51 to 75% physical assistance to perform the task) for sit-to stand transfers, bed/chair transfers, and walking 30 feet using the FWW. During a review of Resident 159’s RNA Weekly Summary, dated 6/20/2025, the RNA Weekly Summary indicated Resident 159 maintained goals of restorative care including ambulation with minimal assistance with use of the FWW and safety belt for 150 to 200 feet, assisted to perform AAROM exercises to arms, and provided PROM to legs daily as tolerated. During a review of Resident 159’s PT Treatment Encounter Note, date 6/20/2025, the PT Treatment Encounter Note indicated Physical Therapy Assistant 1 (PTA 1) attempted to perform transfers and gait training but Resident 159 was resistive and uncooperative. During a review of Resident 159’s PT Treatment Encounter Note, dated 6/23/2025, the PT Treatment Encounter Note indicated Resident 159 stood with maximum assistance and walked five (5) feet in the therapy gym with maximum assistance of two people to support and push the FWW. During a review of Resident 159’s RNA Weekly Progress Report, dated 6/24/2025, the RNA Weekly Progress Report indicated Resident 159 maintained goals of restorative care including ambulation with moderate assistance with use of the FWW for 70 to 80 feet and performed 8-10 repetitions of AAROM exercises to arms and legs. During a review of Resident 159’s RNA Weekly Progress Report, dated 6/27/2025, the RNA Weekly Progress Report indicated Resident 159 maintained goals of restorative care including ambulation with minimal assistance with use of the FWW for 70 to 80 feet and performed 8-10 repetitions of AAROM exercises to arms and legs. During a review of Resident 159’s PT Treatment Encounter Note, dated 6/27/2025, the PT Treatment Encounter Note indicated Resident 159 attempted to perform three sit-to-stand transfers with maximum assistance of two people but had difficulty due to Resident 159’s resistive behavior. During a review of Resident 159’s RNA Weekly Progress Report, dated 7/4/2025, the RNA Weekly Progress Report indicated Resident 159 maintained goals of restorative care including ambulation with minimal assistance without an assistive device for 100 to 150 feet and performed 8-10 repetitions of AAROM and PROM exercises to arms and legs. During a review of Resident 159’s PT Treatment Encounter Note, dated 7/8/2025, the PT Treatment Encounter Note indicated Resident 159 performed four sit-to-stand transfers in the therapy gym’s parallel bars (pair of bars placed a short distance apart to provide support and stability during exercises and gait [manner of walking] training) with maximum assistance of two people. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 159’s RNA Weekly Progress Report, dated 7/11/2025, the RNA Weekly Progress Report indicated Resident 159 maintained goals of restorative care including ambulation with minimal assistance without an assistive device for 100 to 200 feet and performed 8-10 repetitions of AAROM and PROM exercises to arms and legs. During a review of Resident 159’s RNA daily treatment record (record of RNA sessions) for 7/2025, the RNA daily treatment record indicated Restorative Nursing Assistant 8 (RNA 8) provided Resident 159 with AAROM to both arms, PROM to both legs, and ambulation with assistance on 7/14/2025. During a review of Resident 159’s PT Treatment Encounter Note, dated 7/15/2025 by Physical Therapy Assistant 2 (PTA 2), the PT Treatment Encounter Note indicated Resident 159 performed three sit-to-stand transfers in the therapy gym’s parallel bars with maximum assistance of two people. The PT Treatment Encounter Note indicated Resident 159 was unable to achieve upright posture. During a review of Resident 159’s RNA daily treatment record for 7/2025, the RNA daily treatment record indicated Restorative Nursing Assistant 1 (RNA 1) provided Resident 159 with AAROM to both arms, PROM to both legs, and ambulation with assistance on 7/15/2025. During a review of Resident 159’s PT Treatment Encounter Note, dated 7/16/2025 by PTA 1, the PT Treatment Encounter Note indicated PROM was performed to both legs to maintain ROM and prevent loss of motion. The PT Treatment Encounter Note indicated Resident 159 required physical cues to improve participation with poor return demonstration due to cognition. The PT Treatment Encounter Note indicated Resident 159’s ability to perform sit-to-stand transfers and walking were not tested. During a review of Resident 159’s RNA daily treatment record for 7/2025, the RNA daily treatment record indicated Restorative Nursing Assistant 6 (RNA 6) provided Resident 159 with AAROM to both arms, PROM to both legs, and ambulation with assistance on 7/16/2025. During a concurrent interview and record review on 7/16/2025 at 3:16 p.m. with Physical Therapist 1 (PT 1), Resident 159’s PT Evaluation, dated 6/13/2025, was reviewed. PT 1 stated Resident 159 was referred from RNA to PT due to decreased activity tolerance, difficulty with both arms and legs ROM exercises, and difficulty with ambulation. PT 1 stated Resident 159 did not follow commands for strength testing and required maximum assistance for sit-to-stand transfers and walking 30 feet. PT 1 stated PTA 1 provided Resident 159’s PT treatment today. During a concurrent interview and record review on 7/16/2025 at 3:23 p.m. with PTA 1, Resident 159’s PT Treatment Encounter Notes were reviewed for 7/16/2025. PTA 1 stated Resident 159 received PROM to both legs due to poor cognition and inability to follow commands. PTA 1 stated Resident 159 worked on trunk control while seated but resisted sit-to-stand transfers. During an interview on 7/16/2025 at 3:42 p.m. with PTA 2, PTA 2 stated Resident 159 was confused and had difficulty following directions. PTA 2 stated Resident 159 required maximum assistance of two people to perform sit-to-stand transfers due to safety since Resident 159 was heavy and did not initiate movement. PTA 1 stated Resident 159 required maximum assistance of two people and physical cues to perform sit-to-stand transfers at the parallel bars. PTA 2 stated Resident 159 has not walked with PTA 2, and the most Resident 159 has walked with PT services was 30 feet during the PT Evaluation (on 6/13/2025). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/17/2025 at 9:01 a.m. in Resident 159’s room, Resident 159 was observed lying in bed awake and slightly turned to the right side. Resident 159 did not have any expressive verbal language. During an interview on 7/17/2025 at 10:58 a.m. with Restorative Nursing Assistant 8 (RNA 8), RNA 8 stated she floated to different nursing stations to provide RNA services. RNA 8 stated she provided RNA services to Resident 159 on Monday (7/14/2025). RNA 8 checked Resident 159’s care plan and stated Resident 159 walked 120 feet using a FWW and a safety belt, AAROM exercises for both arms, and PROM exercises for both legs. During an observation on 7/17/2025 at 1:09 p.m. in Resident 159’s bedroom, Resident 159’s RNA session with Restorative Nursing Assistant 7 (RNA 7) was observed. Resident 159 was awake while sitting up in a wheelchair but did not respond to questions. RNA 7 sat in a chair next to Resident 159 and provided ROM exercises for both arms and legs. During an observation on 7/17/2025 at 1:52 p.m., RNA 7 walked out of Resident 159’s room into the hallway and returned to the room with the FWW, safety belt, and Restorative Nursing Assistant 1 (RNA 1). RNA 7 wheeled Resident 159 into the hallway and placed the safety belt around Resident 159’s waist. RNA 1 stood on Resident 159’s left side while RNA 7 stood on the right side to physically assist Resident 159 to stand from the wheelchair. Resident 159 was observed in half standing position with the buttocks approximately eight inches above the wheelchair seat’s surface. Resident 159 shuffled some steps forward and sat back down into the wheelchair. RNA 1 and RNA 7 again physically assisted Resident 159 from sitting in the wheelchair to the half standing position. RNA 1 and RNA 7 held onto Resident 159’s safety belt while RNA 1 pushed the FWW to encourage Resident 159 to shuffle both feet forward and RNA 7 pulled the wheelchair immediately behind Resident 159. Resident 159 sat back down into the wheelchair. During an interview on 7/17/2025 at 2:01 p.m. with RNA 1 and RNA 7, RNA 1 stated Resident 159 required maximum assistance of two people to walk five (5) feet. RNA 1 stated Resident 159 needed two people for safety because of the way Resident 159 walked, Resident 159 was heavy, and Resident 159’s inability to follow commands. RNA 1 and RNA 7 stated it was unsafe for one RNA to walk with Resident 159 to manage both the FWW and the wheelchair. RNA 1 and RNA 7 stated it was difficult for Resident 159 to walk even with two RNAs. During an interview on 7/17/2025 at 2:06 p.m. with RNA 8, RNA 8 stated Resident 159 received ROM exercises but did not remember if Resident 159 walked on 7/14/2025. RNA 8 stated she may have walked with Resident 159 at the station but did not remember who assisted RNA 8 with walking Resident 159. During an interview on 7/18/2025 at 4:03 PM with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the DON stated the medical record (in general) contained information on the residents including diagnoses, plan of care, medications, and treatments the residents’ received. (continued on next page)

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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	During a concurrent interview and record review on 7/18/2025 at 4:14 p.m. with the DON and ADON, Resident 159’s RNA daily treatment record for 7/2025 and RNA Weekly Summaries, including 7/11/2025, were reviewed. The DON reviewed the RNA daily treatment record for 7/2025 and stated it did not indicate Resident 159’s ambulation distance with the RNA. The DON reviewed Resident 159’s RNA Weekly Summary, dated 7/11/2025, and stated it indicated Resident 159 walked 100 to 200 feet with the RNA. The DON was informed Resident 159 walked five feet with two RNAs during an observation on 7/17/2025. The DON stated Resident 159’s RNA Weekly Summary, dated 7/11/2025, was not accurate since the RNA daily treatment record did not indicate the ambulation distance. The DON stated Resident 159 would not require PT services if Resident 159 could walk 100 to 200 feet. The DON stated Resident 159’s RNA Weekly Summary indicated the goal for ambulation and not the actual distance. The DON stated the facility would not catch a resident’s decline if the RNA Weekly Summary was not accurate. 2. During a review of Resident 159’s RNA daily treatment record for 7/2025, the RNA daily treatment record indicated Restorative Nursing Assistant 1 (RNA 1) provided Resident 159 with AAROM to both arms, PROM to both legs, and ambulation with assistance on 7/15/2025. During a review of Resident 159’s RNA daily treatment record for 7/2025, the RNA daily treatment record indicated Restorative Nursing Assistant 6 (RNA 6) provided Resident 159 with AAROM to both arms, PROM to both legs, and ambulation with assistance on 7/16/2025. During an interview on 7/16/2025 at 1:25 p.m. with RNA 1, RNA 1 stated Resident 159 did not receive RNA on 7/15/2025 since Resident 159 required the assistance of two people. RNA 1 stated there were no other available RNAs to assist with Resident 159. During a concurrent interview and record review on 7/17/2025 at 2:14 p.m. with RNA 6, Resident 159’s RNA daily treatment record for 7/16/2025 was reviewed. RNA 6 stated Resident 159 received ROM exercises and sit-to-stand transfers but did not walk yesterday (7/16/2025) because the resident required two people for safety. RNA 6 stated Resident 159 required one person to physically assist with walking while the second person needed to follow behind with the wheelchair because Resident 159 would suddenly sit. RNA 6 stated Resident 159’s RNA daily treatment record for 7/16/2025 had a check mark for ambulation but did not provide ambulation. RNA 6 stated Resident 159’s RNA daily treatment record was inaccurate for 7/16/2025. During a concurrent interview and record review on 7/17/2025 at 2:26 p.m. with RNA 1, Resident 159’s RNA daily treatment record for 7/15/2025 was reviewed. RNA 1 stated Resident 159 received ROM exercises but did not perform ambulation on 7/15/2025. RNA 1 stated Resident 159’s RNA daily treatment record was inaccurate for 7/15/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/17/2025 at 2:29 p.m. with RNA 1 and RNA 6, RNA 1 stated Resident 159’s electronic documentation record should have been marked “No” for ambulation and then put the reason ambulation was not completed. RNA 6 stated the electronic documentation record was a new process and did not know how to mark “No” for RNA sessions. RNA 1 and RNA 6 stated Resident 159’s RNA daily treatment record should be but was not accurate. RNA 1 and RNA 6 stated the medical record (in general) was a record of the services provided to the residents. RNA 1 and RNA 6 stated inaccurate medical records could potentially lead to the resident’s decline in mobility. During a concurrent interview and record review on 7/18/2025 at 4:03 p.m. with the DON and ADON, Resident 159’s RNA daily treatment record for 7/2025 was reviewed. DON stated the medical record (in general) contained information on the residents including diagnoses, plan of care, medications, and treatments the residents’ received. The DON reviewed Resident 159’s RNA daily treatment record and stated the check marks indicated Resident 159 was seen for RNA services, including ambulation. The DON stated Resident 159’s RNA daily treatment record was inaccurate if ambulation was not actually provided to Resident 159. During a review of the facility’s policy and procedure (P&P) titled, “Documentation: Nursing Manual – Restorative Nursing Program,” revised 3/1/2015 and reviewed 4/28/2025, the P&P’s purpose included to ensure that residents’ progress in the Restorative Nursing Program was documented accurately and timely. c. During a review of Resident 240’s admission Record, the admission Record indicated the facility admitted Resident 240 on 4/11/2024 with diagnoses including congestive heart failure (heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), age-related cognitive (ability to think, understand, learn, and remember) decline, and muscle weakness. During a review of Resident 240’s physician’s orders, dated 8/9/2024, the physician’s o[TRUNCATED]

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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 appropriate infection control practices for one of six sampled residents (Residents 21) reviewed under the Nutrition care area by failing to: 1. Implement Enhanced Barrier Precautions (EBP, sometimes referred to as enhanced standard precautions, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, microorganisms, mainly bacteria, that are resistant to one or more classes of antibiotics] that uses targeted gown and glove use during high contact resident care activities) for Resident 21 during indwelling catheter (a flexible tube placed in the bladder to drain urine) care (the act of cleaning the catheter and area around the catheter). 2. Ensure Certified Nursing Assistant (CNA) 1 performed hand washing who provided peri-care to Resident 62, who had an indwelling urinary catheter (a flexible plastic tube [a catheter] inserted into the bladder [a hallow organ that stores urine] to provide continuous urinary drainage). 3. Failing to implement EBP for Resident 62 when CNA 1 provided peri-care to the resident who had an indwelling urinary catheter. These deficient practices had the potential to spread infections and illnesses to other residents, visitors, and staff. Findings: a. During a review of Resident 21’s admission Record (AR), the AR indicated the facility originally admitted the resident on 1/18/2024 and most recently admitted the resident on 11/9/2024 with diagnoses that included metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), carcinoma in situ of vulva (abnormal cells are found on the surface of the vulvar [external female genitals] skin), malignant neoplasm (cancer) of unspecified site of female breast, and Alzheimer’s disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 21’s History and Physical (H&P), dated 4/11/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 21’s Minimum Data Set (MDS – resident assessment tool) dated 5/5/2025, the MDS indicated the resident usually was able to understand others and usually was able to make herself understood. The MDS further indicated Resident 21 was dependent on staff for eating, toileting, bathing, dressing, oral and personal hygiene, and mobility. During a review of Resident 21’s Order Recap Summary, the Order Recap Summary indicated the following physician’s orders: -Indwelling catheter care, cleanse with ready bath bathing cloths (2 Licensed Vocational Nurses required), every 12 hours and as needed, dated 7/11/2025. During a review of Resident 21’s Care Plan (CP) regarding the use of an indwelling catheter, initiated 4/11/2025, the CP indicated the resident was at risk for infection. The CP indicated a goal that the resident would have no signs or symptoms of infection with interventions that included providing catheter care per protocol. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/17/2025 at 9:30 a.m. with Treatment Nurse (TN) 2, Licensed Vocational Nurse (LVN) 5, and Certified Nursing Assistant (CNA) 2; observed Resident 21’s indwelling catheter care. Observed TN 2, LVN 5, and CNA 2 enter Resident 21’s room wearing masks and gloves. Observed TN 2, LVN 5, and CNA 2 did not don (put on) gowns upon entering the room. Observed TN 2 provided indwelling catheter care to Resident 21 while LVN 5 and CNA 2 were at bedside assisting with moving the resident and adjusting the sheets. Observed TN 2, LVN 5, and CNA 2 did not wear gowns while providing and assisting with indwelling catheter care. During a follow-up interview on 7/17/2025 at 12:57 p.m. with CNA 2, CNA 2 stated CNA 2 did not wear a gown when providing care to Resident 21 because Resident 21 was not on any kind of isolation precautions (preventative steps taken by healthcare team members and staff at healthcare facilities to prevent the spread of infections). CNA 2 stated CNA 2 did not wear a gown while assisting with Resident 21’s indwelling catheter care on 7/17/2025. During a concurrent interview and record review on 7/17/2025 at 1:10 p.m. with TN 2, TN 2 stated for a short period of time EBP were implemented in the facility. TN 2 stated the facility stopped implementing EBP and TN 2 did not know why. TN 2 stated EBP includes wearing a gown, masks, and gloves when providing care for residents with foley catheters because residents with indwelling devices are vulnerable to the spread of infection. TN 2 stated TN 2 did not implement EBP and don a gown when providing indwelling care to Resident 21 on 7/17/2025. During an interview on 7/17/2025 at 4:18 p.m. with the Infection Prevention Nurse (IP), the IP stated EBP was discontinued at the facility in 3/2025 because there was an Infection Prevention Education Series which recommended that EBP was only necessary for residents with MDROs. The IP stated the facility did not have EBP because the residents did not have any MDROs. During an interview on 7/18/2025 at 9:55 a.m. with the IP, the IP stated she was unable to locate the Infection Prevention Education Series which recommended the discontinuation of EBP if residents did not have any MDROs. The IP stated she was mistaken regarding the EBP recommendations and did not know EBP should be implemented even if the resident did not have any MDROs. The IP stated residents requiring EBP do not have any infection and want to prevent an infection. The IP stated EBP will be implemented at the facility today (7/18/2025). b. During a review of Resident 62’s AR, the AR indicated the facility admitted the resident on 3/12/2024 with diagnoses including Alzheimer’s disease, dementia (a progressive state of decline in mental abilities), and neuromuscular dysfunction of bladder (a condition where the nerves connecting the brain and bladder are damaged or not working properly, leading to problems with bladder control and emptying). During a review of Resident 62’s H&P, dated 5/26/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 62’s MDS, dated [DATE], the MDS indicated the resident had adequate hearing, clear speech, usually makes self understood, and usually had the ability to understand others. The MDS indicated the resident was dependent on staff for toileting, personal hygiene, and shower/bathing self. The MDS indicated the resident had an indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 62’s Order Review History Report (ORHR), dated 5/26/2024, the ORHR indicated catheter care every shift. During a review of Resident 62’s CP with focus on “Has Foley Catheter: Potential for infection, ” dated 5/27/2024, the CP indicated interventions including provide peri care every shift per protocol and as needed. During an observation on 7/17/2025 at 7:48 a.m., inside and outside of Resident 62’s room, no EBP signage and no personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) noted. During a concurrent observation and interview on 7/17/2025 at 9:46 a.m. with CNA 1, at Resident 62’s bedside, CNA 1 without wearing a gown, put on gloves in a double-gloving technique. CNA 1 stated he will provide care to Resident 62 and get her ready for the day. CNA 1 cleansed the resident’s perineal area using a peri wash soap-soaked cloth and then dried with one towel. CNA 1 cleansed the resident’s bottom, noted with bowel movement, using a second periwash-soaked washcloth and dried using a second towel. CNA 1 removed the first layer of his gloves and continued with the care. CNA 1 applied adult pads and removed soiled chux (disposable under pads) and put on clean chux underneath the resident. CNA 1 secured the resident’s adult pads and then removed the resident’s heel protectors. CNA 1 removed his pair of gloves, continued with the care, placed pillows and blankets on resident and adjusted bed to level to low. CNA 1 applied new gloves and emptied the resident’s urinary drainage bag into a container. CNA 1 stated the resident’s urinary output is 425 milliliters (ml- a unit of measurement). CNA 1 emptied the container in the restroom and performed hand washing with soap and water. During an interview on 7/17/2025 at 10:16 a.m. with CNA 1, CNA 1 stated when he is alone providing care to the resident he would wear double gloves. CNA 1 stated he did not have to leave the resident alone with her bed all the way up to wash his hands. CNA 1 stated they are supposed to take off the gloves and wash their hands in between. CNA 1 stated this is for infection control. During an interview on 7/17/2025 at 10:51 a.m. with CNA 1, CNA 1 stated Resident 62 is not in any isolation. CNA 1 stated he does not know about EBP. CNA 1 stated for example contact isolation they would have a sign outside the room and a cart that would have the gown and gloves. CNA 1 stated the sign tells them what to wear and a trash bin inside the room for the disposal of the PPE. CNA 1 stated there is no isolation signage inside the room either. During an interview on 7/18/2025 at 11:57 a.m. with the Infection Preventionist (IP), the IP stated she has been the IP of the facility since 12/2024. The IP stated staff are expected to wear only one pair of gloves and double gloving is not part of the facility’s policy. The IP stated the EBP P&P was discontinued and had it clarified and reinstated starting today, 7/18/2025. The IP stated they followed the local health department guidance but reviewed from the CDC to continue the EBP P&P. The IP stated the EBP are for residents with indwelling catheters, gastrostomy tubes, central lines, and residents with wounds. The IP stated the EBP is to prevent MDROs. The IP stated the potential for not implementing EBP are residents getting an infection that becomes an MDRO. The IP stated staff are to perform hand washing before and after care and when changing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/18/2025 at 1:40 p.m. with the ADON and the DON, the facility P&P regarding EBP was reviewed. The ADON stated the facility stopped implementing EBP after the facility IP took training with the local health department that indicated EBP was no longer necessary. The DON stated EBP should have been implemented, and they were not. The DON stated when EBP was not implemented there was a potential for infection in residents from exposure to MDROs. During a concurrent interview and record review on 7/18/2025 at 1:47 p.m. with the DON, the DON stated staff are expected to wash their hands before, during, and after peri-care. The DON stated all staff are expected to change gloves in between and use only one pair. The DON stated that when this is not followed there is a potential transmission of infection. During a concurrent interview and record review on 7/18/2025 at 1:40 p.m. with the Assistant Director of Nursing (ADON) and Director of Nursing (DON), the facility P&P regarding EBP was reviewed. The ADON stated the facility stopped implementing EBP after the facility IP took a training with the local Department of Public Health that indicated EBP was no longer necessary. The DON stated EBP should have been implemented, and they were not. The DON stated when EBP were not implemented there was a potential for infection in residents from exposure to MDROs. During a review of the facility policy and procedure (P&P) titled, “Standard and Enhanced Barrier Precautions,” last reviewed 4/28/2025, the P&P indicated the purpose of the P&P was to ensure the use of appropriate personal protective equipment to improve infection control as required in the care of residents. The Facility will utilize current guidance from the Centers for Disease Control (CDC) and the Centers for Medicare & Medicaid Services (CMS) to determine the appropriate PPE to be utilized during the care of residents to minimize the risk of infection or spread of infection. 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 when contact precautions do not otherwise apply and/or transmission such as presence of indwelling devices (e.g., indwelling urinary catheter). For residents whom EBP are indicated, EBP should be used when performing the following high-contact resident care activities: -Dressing -Bathing/showering -Transferring -Providing hygiene -Changing linens -Changing briefs or assisting with toileting -Device care or use: urinary catheter EBP are intended to be in place for the duration of a resident's stay in the Facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at high-risk. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled, “Hand Hygiene,” last reviewed 4/28/2025, the P&P indicated the facility considers hand hygiene the primary means to prevent the spread of infections. The P&P indicated facility staff must perform hand hygiene procedures by washing hands with soap and water in circumstances including after using the bathroom, when soiled with visible dirt or debris. The P&P indicated alcohol-based hand hygiene products can and should be used to decontaminate hands after removing PPE and before moving to another resident in the same room or exiting the room. The P&P indicated the use of gloves does not replace hand hygiene procedures. During a review of the facility P&P titled, “Perineal Care,” last reviewed 4/28/2025, the P&P indicated perineal care is provided as part of a resident’s hygienic program. The P&P indicated the procedure included after after washing, rinsing, and drying the resident’s buttocks and peri-anal area without contaminating the perineal area to remove the wet linen, placing dry linens or briefs or both underneath the resident, reposition the resident, then remove gloves and wash hands or use alcohol-based hand sanitizer. The P&P indicated “do not touch anything with soiled gloves after procedure (ie. Curtain, side rails, clean linen, call bell, etc.).” The P&P indicated the facility staff to put on clean gloves, clean and return all equipment to its proper place and to place soiled linen in proper container, remove gloves, and then wash hands.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to implement its policy for antibiotic (medication used to treat infection) stewardship (efforts in doctors' offices, hospitals, long-term care facilities, and other health care settings to ensure that antibiotics are used only when necessary and appropriate, means prescribing the right drug at the right dose at the right time for the right duration) program and infection prevention and control program for four of five sampled residents (Residents 188, 117, 60, and 44) by: 1.Failing to monitor Resident 188 for the adverse effects (undesired or harmful effects) of cefdinir (antibiotic medication used to treat infection) on the following dates and times: a. 7 a.m., to 3 p.m. on 6/26/2025, and 6/27/2025. b. 3 p.m., to 11 p.m., on 6/29/2025. c.11 p.m., to 7 a.m. on 6/27/2025, 67/28/2025, and 6/29/2025. 2.Failing to monitor Resident 117 for the adverse effects of amoxicillin potassium clavulanate (antibiotic medication used to treat infection) on the following dates and times: a. 7 a.m. to 3 p.m. on 6/24/2025. b. 11 p.m. to 7 a.m. on 6/24/2025, 6/25/2025, and 6/26/2025, 3.Failing to monitor Resident 106 for the adverse effects of azithromycin (antibiotic medication used to treat infection) on the following dates and times: a. 3 p.m., to 11 p. m. on 6/4/2025, and 6/6/2025. b. 11 p.m. to 7 a.m. on 6/3/2025, 6/4/2025, and 6/6/2025. 4.Failing to monitor Resident 44 for the adverse effects of sulfamethoxazole-trimethoprim (antibiotic medication used to treat infection) on the following dates and times: a. 7 a.m. to 3 p.m. on 7/13/2025. b. 3 p.m. to 11 p.m. on 7/13/2025. c. 11 p.m. to 7 a.m. on 7/12/2025, 7/13/2025, and 7/14/2025. 5. Failing to complete Infection Control Surveillance log (a document or system used to track and monitor infections within a specific setting, like a healthcare facility, to identify trends, outbreaks [a sudden increase in the number of cases of a disease], and potential areas for improvement in infection prevention and control practice) dated 6/2025. The Infection Control Surveillance log did not indicate Residents 188, 117, and 106's signs of infection, mental status (mental state), culture result (a laboratory procedure where a sample of body fluid or tissue is tested to know what organism is growing), x-ray result (imaging test that can spot problems areas in the body) and if the infection is either community acquired (infection was from home or community) or nosocomial (infection from the hospital). These failures had the potential to increase antibiotic resistance (do not respond to a drug) from unnecessary or inappropriate antibiotic use and had the potential for Residents 188, 117, 106, and 44 to experience an adverse reaction. Cross reference to F882 Findings: a. During a review of Resident 188's admission Record, the admission Record indicated the facility initially admitted Resident 188 on 12/4/2024, and readmitted on [DATE], with diagnoses that included atherosclerotic heart disease (a condition where fatty deposits build up inside your arteries, making them narrow and stiff), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and benign prostatic hyperplasia (BPH-a common condition in older men where the prostate gland grows larger than normal) with lower urinary tract infection (UTI-an infection in the bladder/urinary tract). During a review of Resident 188'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 2/6/2025, the H&P indicated Resident 188 had fluctuating capacity to understand and make decisions. During a review of Resident 188's Minimum Data Set (MDS-a resident assessment tool), dated 5/7/2025, the MDS indicated Resident 188's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. During a review of Resident 188's Order Audit Report (Physician Order), dated 6/24/2025, the Order Audit Report indicated an order for cefdinir capsule 300 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount), one capsule by mouth every 12 hours for UTI for three days. During a review of Resident 188's Care Plan dated 6/24/2025 on at risk for adverse reaction, the Care Plan indicated an intervention to notify the physician if adverse reaction due to antibiotic occurs. During a review of Resident 188's Medication Administration Record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 6/2025, the MAR indicated Resident 188 received cefdinir from 6/26/2025, at 9 a.m., to 6/28/2025, at 9 p.m. During a concurrent interview, and record review on 7/15/2025, at 9:52 a.m., with the Infection Preventionist (IP), Resident 188's Progress Notes, dated 6/26/2025, to 6/30/2025, were reviewed. The IP stated nurses monitor residents for the adverse effects of antibiotics every shift until one to two days after the completion of antibiotic dose. The IP stated the monitoring of adverse effects were documented in the residents Progress Notes. The IP stated if residents were not monitored for the adverse effects of antibiotics, residents could

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	07/18/2025

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Infection Preventionist performed the duties of the position by failing to implement the antibiotic (medication used to treat infection) stewardship program (efforts in doctors' offices, hospitals, long-term care facilities, and other health care settings to ensure that antibiotics are used only when necessary and appropriate, means prescribing the right drug at the right dose at the right time for the right duration) and the infection prevention and control program for four of five sampled residents (Residents 188, 117,106, and 44) by: 1.Failing to completely fill out the Infection Control Surveillance log (a documented record used to systematically track and analyze healthcare-associated infections and other infectious diseases within a healthcare facility), dated 6/2025, for Resident 188, 117 and 106. 2.Failing to ensure Resident 188, 117, 106, and 44 were monitored for the adverse effects (undesired or harmful effects) of antibiotic. These failures had the potential to increase antibiotic resistance (do not respond to a drug) from unnecessary or inappropriate antibiotic use and had the potential for Residents 188, 117, 106, and 44 to experience an adverse reaction. Cross reference to F881 Findings: a. During a concurrent interview, and record review on 7/15/2025, at 9:52 a.m., with the IP, facility's Infection Control Surveillance Log, dated 6/2025, was reviewed. The IP stated she (IP) works full time as the facility's IP and the Risk Management Nurse (RMN). The IP stated she (IP) did not completely fill out the Infection Control Surveillance Log. The IP stated she (IP) should have completed the Infection Control Surveillance Log to keep an accurate tracking of Residents 188, 117 and 106's infections. The IP stated for Residents 188, 117, and 106, the Infection Control Surveillance had the following missing information: 1. signs and symptoms of infection, 2. residents' mental status (mental state), 3. culture result (a laboratory procedure where a sample of body fluid or tissue is tested to know what organism is growing), 4. x-ray result (imaging test that can spot problems areas in the body), 5. if the infection is community acquired (infection started from home or community) 6. if the infection was nosocomial (infection started from the hospital). b. During a review of Resident 188's admission Record, the admission Record indicated the facility initially admitted Resident 188 on 12/4/2024, and readmitted on [DATE], with diagnoses that included atherosclerotic heart disease (a condition where fatty deposits build up inside your arteries, making them narrow and stiff), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and benign prostatic hyperplasia (BPH-a common condition in older men where the prostate gland grows larger than normal) with lower urinary tract infection (UTI-an infection in the bladder/urinary tract). During a review of Resident 188'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 2/6/2025, the H&P indicated Resident 188 had fluctuating capacity to understand and make decisions. During a review of Resident 188's Minimum Data Set (MDS-a resident assessment tool), dated 5/7/2025, the MDS indicated Resident 188's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. During a review of Resident 188's Order Audit Report (Physician Order), dated 6/24/2025, the Order Audit Report indicated an order for cefdinir (antibiotic medication used to treat infection) capsule 300 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount), one capsule by mouth every 12 hours for UTI for three days. During a review of Resident 188's Care Plan dated 6/24/2025 on at risk for adverse reaction, the Care Plan indicated an intervention to notify the physician if adverse reaction due to antibiotic occurs. During a review of Resident 188's Medication Administration Record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 6/2025, the MAR indicated Resident 188 received cefdinir from 6/26/2025, at 9 a.m., to 6/28/2025, at 9 p.m. During a concurrent interview, and record review on 7/15/2025, at 9:52 a.m., with the Infection Preventionist (IP), Resident 188's Progress Notes, dated 6/26/2025, to 6/30/2025, were reviewed. The IP stated nurses monitor residents for the adverse effects of antibiotics every shift until one to two days after the completion of antibiotic dose. The IP stated the monitoring of adverse effects were documented in the residents Progress Notes. The IP stated if residents were not monitored for the adverse effects of antibiotics, residents could have adverse reaction, which could result in delay in physician notification and cause delay in resident care. The IP stated there was no documented monitoring for the adverse effects of cefdinir in Resident 188's Progress Notes on the following dates and times. a. 7 a.m. to 3 p.m. on 6/26/2025 and 6/27/2025. b. 3 p.m. to 11 p.m. on 6/29/2025. c. 11 p