STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555616	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ararat Post Acute	1230 E. Windsor Rd. Glendale, CA 91205

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44429 Based on interview and record review, the facility failed to notify the physician, for one of three sampled residents (Resident 1), who was assessed as a moderate risk for falls, and sustained an unwitnessed fall on 11/13/214. This deficient practice had the potential to result in the delay of care and services to Resident 1. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included osteoporosis and atrial fibrillation (a heart condition that causes an irregular and often fast heartbeat). During a review of Resident 1 ' s Nursing Admission Screening/History dated 11/11/2024 at 4:08 PM, the Nursing Admission Screening/ History indicated Resident 1 was alert and orientated to person, place, and time. The Screening indicated that Resident 1 had bilateral (affecting to both the right and left side of the body) upper and lower extremities (part of the body) discoloration. A Review of Resident 1 ' s Fall Risk assessment dated [DATE] at 6:50 PM, the Fall Risk Assessment indicated Resident 1 was assessed as moderate risk for falls. During a review of Resident 1 ' s Risk for Fall Care Plan initiated 11/13/24, the Risk for Fall Care Plan indicated Resident 1 was at risk for fall related to weakness, poor safety judgment, side effects of multiple medications and requires assistance with toileting. The care plan indicated interventions including a safe environment, reachable call light and bed in low position. During a review of Resident 1 ' s Anticoagulant (medications that prevent or reduce blood clotting) and Antiplatelet (medications that prevent blood cells called platelets from clumping together and forming clots) Care Plan, initiated 11/13/24, the Anticoagulant and Antiplatelet Care Plan indicated goals that Resident 1 would be from adverse reactions related to anticoagulant use. The care plan interventions indicated daily skin inspection and monitor for bruising and sudden changes in mental status. (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

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s History and Physical Examination (HPE, a comprehensive physician ' s note regarding the assessment of the Patient ' s health status) dated 11/14/2024, the HPE indicated Resident 1 had fluctuating (changing frequently) capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS, a resident assessment tool) dated 11/15/2024, the MDS indicated Resident 1 had moderately impaired cognition (thought process) and required substantial/maximum assistance (helper did more than half the effort) for activities of daily living (basic tasks such as: eating, dressing, bathing, using the toilet and getting in and out of the bed or chair. During an interview on 11/21/2024 at 9:30 AM with the Director of Nursing (DON), the DON stated Resident 1 was alert and able to answers questions appropriately and was initially assessed as moderate risk for falls. The DON stated that Resident 1 required frequent observations due to Resident 1 ' s history of dementia (neurological conditions affecting the brain that worsen over time). During a telephone interview on 11/21/2024 at 10:01 AM with family member (FM) 2, FM 2 stated that FM 1 ' s family member reported to her on Friday, 11/15/2024 that Resident 1 reported falling on 11/13/2024 with an injury to his left elbow which was reported to registered nurse 1. FM2 stated she was not informed regarding Resident 1 falling on 11/13/24. During an interview on 11/21/2024 at 4:32 PM with the DON, the DON stated that she forgot that the Dietary Manager (DM) reported to the DON that Resident 1 fell on [DATE] with an injury to his left elbow. The DON stated on 11/13/2024, the DON conducted a body assessment on Resident 1 and that there was no injury observed on Resident 1 ' s left elbow. The DON stated that she did not document the unwitnessed fall on 11/13/24 because there was no injury. The DON stated she did not notify the physician (MD 1) regarding the reported unwitnessed fall. The DON stated she should have notified MD 1 regarding Resident 1 ' s fall on 11/13/24 to prevent further injury. During a telephone interview on 11/25/2024 at 10:30 AM with the DM, DM stated Resident 1 informed the DM in the afternoon of 11/13/2024 that Resident 1 fell the morning of 11/13/24. Resident 1 stated he could not reach his call light and was barely able to get back in bed. DM stated that Resident 1 could not recall what specific time he fell or the reason for attempting to get out of bed. DM stated that she immediately notified the DON and that the DON went into the room and assessed Resident 1. During a review of the facility ' s policy and procedure (P&P) titled Change of Condition Notification revised on 1/1/2017, the P&P indicated to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. The P&P indicated the facility would promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal representative when the resident endures a significant change in their condition\caused by, but not limited to: an injury/accident, a significant change in the resident's physical, cognitive, behavioral or functional status, and a significant change in treatment. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s P&P titled Response to Falls revised 3/1/2015, the P&P indicated to ensure the facility responds quickly and appropriately to resident falls in a manner that addresses both resident ' s immediate needs and longer-term fall prevention. The P&P indicated resident experiencing the fall will be promptly assessed and treated for injuries. The P&P indicated the licensed nurse will notify the attending physician of the fall and implement any new physician orders. The P& P indicated a Licensed Nurse will document notification of physician and responsible party.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44429 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), was provided appropriate care and services, that was resident centered, by failing to: 1. Develop an individualized care plan that includes resident specific care needs and interventions for Resident 1 who was assessed at moderate risk for falls in accordance with the facility's policy and procedure for Care Planning. 2. Develop an individualized care plan that includes resident specific care needs and interventions for Resident 1 who had a history and diagnoses of osteoporosis (a bone disease that causes bones to become weak and more likely to break) to prevent fractures (a break in a bone, either partial or complete). 3. Monitor and document a neurological assessment (neurocheck: a non-invasive procedure that can help identify and treat injuries sustained after a fall) after Resident 1 fell on [DATE] (5 days after admission), in accordance with the facility's P&P titled Neurological Assessment. 4. Assess and inform the Physician before the administration of Resident 1 ' s prescribed medication, Apixaban (medication to thin the blood and prevent blood clots) 2.5mg (unit of measure) by mouth (PO) twice a day (BID) at 5PM, after Resident 1 fell on [DATE], in accordance with professional standards of practice and the facility P&P on Neurological Assessment. 5. Review and address the Black Box warning (when serious adverse reactions or special problems occur, particularly those that may lead to death or serious injury) of the drug-to-drug interaction automatically populated in the facility ' s electronic medical record system for licensed nurse to monitor risk for adverse consequences (an undesired effect of a drug or other type of treatment) while on a black box warning medication (Apixaban), in accordance with the facility ' s P&P titled, Medication- Black Box Warning and care plans for the use of Anticoagulant and Antiplatelet. This deficient practice of not addressing automatic generated prompts for drug warnings had the potential for licensed nurses (LN) to disregard potential adverse effects to Resident 1 and other residents in the facility who were on a black box warning medication. 6. Promptly assess and complete a post fall assessment, investigation, document notification of physician and responsible party, a detailed progress note, document the resident's condition in the resident's medical record every shift for 72 hours and revise resident's care plan as necessary for Resident 1 ' s unwitnessed fall on [DATE], as verbalized by Resident 1, on [DATE], in accordance with the facility ' s P&P, titled Response to Falls. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The deficient practices of failing to develop a care plan, monitor and document Resident 1 ' s neurocheck consistently, and not notifying the physician and assessing Resident 1 after an alleged fall on [DATE] resulted in Resident 1 sustaining a fall on [DATE] resulting in a 2x2 size bump on the forehead and altered level of consciousness (ALOC: reduced alertness or inability to be aroused), requiring the resident to be transferred to the General Acute Care Hospital (GACH) on [DATE] and had the potential to place other residents at risk for not obtaining care and services tailored to residents specific needs. Findings: During a review of Resident 1 ' s GACH Records dated [DATE], prior to resident ' s admission to the facility, the GACH Records indicated Resident 1 had a history of osteoarthritis and osteoporosis. The GACH record did not indicate that Resident 1 had any previous fractures. During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included osteoporosis and atrial fibrillation (a heart condition that causes an irregular and often fast heartbeat). During a review of Resident 1 ' s Nursing Admission Screening/History dated [DATE] at 4:08 PM, the Nursing Admission Screening/ History indicated Resident 1 was alert and orientated to person, place and time. The Screening indicated that Resident 1 had bilateral (affecting to both the right and left side of the body) upper and lower extremities (part of the body) discoloration. A Review of Resident 1 ' s Fall Risk assessment dated [DATE] at 6:50 PM, the Fall Risk Assessment indicated Resident 1 was assessed as moderate risk for falls. During a review of Resident 1 ' s Risk for Fall Care Plan initiated on [DATE], the Risk for Fall Care Plan indicated, Resident 1 was at risk for fall related to weakness, poor safety judgment, side effects of multiple medications and requires assistance with toileting. The care plan indicated interventions including a safe environment, reachable call light and bed in low position. During a review of Resident 1 ' s Order Summary Report for ,d+[DATE], the Order Summary Report indicated Resident 1 was prescribed Apixaban (a blood thinner medication to thin the blood and prevent blood clots) 2.5mg (unit of measure) by mouth twice a day (BID), Aspirin (prevents blood clots) 81mg by mouth once a day and Plavix (prevents blood clots) 75mg my mouth once a day. The Report indicated anticoagulation (prevents blood clots) medication required monitoring for discolored urine, black tarry stool, sudden severe headache, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status, shortness of breath and nose bleeds. During a review of Resident 1 ' s Anticoagulant (medications that prevent or reduce blood clotting) and Antiplatelet (medications that prevent blood cells called platelets from clumping together and forming clots) Care Plan , initiated [DATE], the Anticoagulant and Antiplatelet Care Plan indicated goals that Resident 1 would be free from adverse reactions related to anticoagulant use. The care plan interventions indicated daily skin inspection and to monitor for bruising and sudden changes in mental status. During further review of Resident 1's clinical record from [DATE]-[DATE], the clinical record indicated no documented evidence of a care plan for resident's diagnoses of osteoporosis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Nursing Progress Notes dated [DATE] at 2:47 PM, indicated a drug-to-drug interaction alert/warning generated by the facility ' s electronic medical record, which indicated that the system had identified a possible drug interaction with the following orders: Aspirin oral capsule 81 mg, severity: severe, and interaction: Aspirin may enhance the anticoagulant effects of direct oral anticoagulant Apixaban 2.5mg. During a review of Resident 1 ' s Minimum Data Set (MDS, a resident assessment tool) dated [DATE], the MDS indicated Resident 1 had moderately impaired cognition (thought process) and required substantial/maximum assistance for activities of daily living and getting in and out of the bed or chair. During a review of Resident 1 ' s Post Change in Condition (COC)/Situation, Background, Assessment, Recommendation (SBAR) dated [DATE] at 4:04 PM, the Post COC/SBAR indicated Resident 1 sustained a fall and the Medical Doctor 1(MD 1) was notified, and MD 1 ordered to monitor, observe, and apply ice to bump, located on the left side of Resident 1 ' s forehead. During a review of Resident 1 ' s Medication Audit Report dated [DATE], the Medication Audit Report indicated Apixaban 2.5mg oral tablet was administered at 5:10 PM by Licensed Vocational Nurse (LVN) 1. During a review of Resident 1 ' s Nursing Progress Notes dated [DATE] at 4:45 PM, the Nursing Progress Note indicated Certified Nursing Assistant (CNA 2) found Resident 1 on the floor, laying on the right side with Resident 1 ' s head located beside the foot of the bed (bottom of bed).The progress note indicated Resident 1 sustained a bump to the left side of the forehead measuring 2cm (unit of measurement) by 2cm, and that MD 1 was notified regarding Resident 1 ' s fall. The Progress Note indicated MD ordered for monitoring and to apply and ice pack to Resident 1 ' s bump. During a review of Resident 1 ' s 72 hours Neuro-check List for unwitnessed fall with left forehead bump, dated [DATE], the 72 hours Neuro Check List indicated Resident 1 ' s neuro assessment was not documented at 5:30PM to assess Resident 1 ' s blood pressure, vital signs, level of consciousness, pupils, and hand grip. During a review of Resident 1 ' s Nursing Progress Note dated [DATE] at 6:25 PM, the Nursing Progress Note indicated at 5:00PM Resident 1 ' s prescribed medication, apixaban was administered. The progress note indicated at 5:45PM Family Member (FM 2) 2 was screaming from Resident 1 ' s room requesting assistance. The progress note indicated Resident 1 was agitated and his body was shaking, his eyes were closed, and FM 2 was holding Resident 1 ' s body down. The progress note indicated Resident noted with shakiness body and eyes closed and daughter holding him down to bed/ controlling the shakiness. The progress note indicated that FM 2 called 911 (emergency services) on her personal phone. During a review of Resident 1 ' s Nursing Progress Noted dated [DATE] at 6:45 PM, the Nursing Progress Note indicated Resident 1 was non-verbal, with all extremities shaking, and was not responding to FM 2 ' s verbal calls to Resident 1. The Progress Note indicated Registered Nurse (RN) 1 could not obtain vital signs (measurements of breathing rate, temperature, pulse rate and blood pressure) due to Resident 1 ' s continuous shaking. During a review of Resident 1 ' s Order Summary Report, the Order Summary Report indicated an order to transfer Resident 1 to the GACH via 911 (emergency services) for evaluation on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s GACH Records dated [DATE], the GACH Records indicated Resident 1 was transferred to the GACH for altered mental status and concerns for seizures (uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements (stiffness, twitching or limpness). The GACH record indicated after Resident 1 had a computed tomography (CT - a scan that helps detect injuries) scan to rule out intercranial hemorrhage (Bleeding in the head) at 6:50PM Resident 1 went into bradycardia (slow heart rate) and one dose of epinephrine (medication to treat slow heart rate) 20 micrograms (mcg - unit of measure) intravenous (in the vein) was administered to Resident 1 ' s right arm. The GACH records indicated Resident 1 continued to have bradycardia and went into pulseless electrical activity (PEA - a condition where the heart stops beating). The GACH records indicated that Resident 1 received a total of 4 doses of epinephrine with high quality cardiopulmonary resuscitation (CPR - a procedure to restart breathing and heartbeat) performed, as well as required 2 doses of sodium bicarbonate (medication used to treat too much acid in the body fluids) and calcium chloride (medication used during CPR to help regain a heartbeat). The GACH records indicated Resident 1 was intubated (inserting a breathing tube through the mouth) during the cardiac arrest. The GACH records indicated that an electrocardiogram (EKG - a test to record electrical signals in the heart) was obtained postcardiac arrest at 7:40PM and Resident 1 ' s heart rate was 70 beats per minute (a unit of measurement). The GACH records indicated Resident 1 was transferred to the intensive care unit (ICU - a hospital ward that provides critical care and life support for patients who are seriously injured) while on Levophed (medication used to treat life threating low blood pressure) 25 mcg/kilogram (kg - unit of measurement) and Resident 1 ' s condition was critical. During further review of the GACH records, the GACH Records indicated that on [DATE] at 11:36 PM an x-ray was performed on Resident 1 and indicated a proximal (closer to the center of the body) right femur (longest and heaviest bone in the body) fracture. During an interview on [DATE] at 9:30 AM with the Director of Nursing (DON), the DON stated that Resident 1 was admitted on [DATE] with diagnosis of pneumonia (infection in the lungs) and had no previous fractures upon admission. The DON stated Resident 1 was alert and able to answers questions appropriately and was initially assessed as moderate risk for falls. The DON stated that Resident 1 required frequent observations due to Resident 1 ' s history of dementia (neurological conditions affecting the brain that worsen over time). The DON stated that Resident 1 had an unwitnessed fall on [DATE] around 3pm and was found on the floor in a right-side lying position and a body check was conducted by RN 1. The DON stated that Resident 1 had a head injury from the fall and sustained a bump to the left side of Resident 1 ' s forehead. The DON stated on Saturday, [DATE] around 4:30 PM, FM 2 arrived at the facility to assist Resident 1 with meals. The DON stated that FM 2 came to the nursing station at around 5:40 PM calling for help because Resident 1 was nonresponsive, and the resident ' s entire body was shaking. The DON stated that RN 1 went to assess Resident 1 and FM 2 had called 911. The DON stated the paramedics arrived around 6pm and Resident 1 was transferred to the GACH. During a telephone interview on [DATE] at 10:01AM with FM 2, FM 2 stated that LVN 1 entered Resident 1 ' s room at 5:10 PM and administered Apixaban 2.5 mg to Resident 1. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on [DATE] at 10:05AM with FM 2, stated that on Saturday, [DATE] she received a call from the facility at 4:10PM and was informed that Resident 1 sustained a fall with a head injury. FM 2 stated she arrived at the facility at 4:35 PM and observed a golf ball size bump on the left side of Resident 1 ' s forehead. FM 2 stated that Resident was alert but was having episodes of confusion and had difficult time speaking and could not formulate words. FM 2 stated Resident 1 was alert prior to his admission to the facility on [DATE]. FM 2 stated that at 5:40 PM Resident 1 became nonresponsive and started having seizure like shaking to his upper and lower extremities. FM 2 stated she ran to the nursing station and called for help, and RN 1 and LVN 1 came to Resident 1 ' s room. FM 2 stated that she informed RN 1 to call 911 because Resident 1 was nonresponsive and the resident ' s upper and lower extremities were shaking nonstop. FM 2 stated that CNA 1 told FM2 that this had happened before and not to panic. FM 2 stated the paramedics arrived at the facility at approximately 6pm. During an interview on [DATE] at 2:37 PM with licensed vocational nurse (LVN) 1, LVN 1 stated that on [DATE] at 3:45 PM CNA 1 called for assistance in Resident 1 ' s room since Resident 1 was found lying down on the floor. LVN 1 stated that she entered Resident 1 room with RN 1 and found Resident 1 positioned on his right side with a bump observed to the left side of Resident 1 ' s head measuring 2x2 cm. LVN 1 stated that Resident 1 had an unwitnessed fall, then sustained a bump on the left side of his head which contacted the side of bed. During a concurrent interview and record review of Resident 1 ' s Neuro Check List on [DATE] at 2:41 PM, LVN1 stated she was responsible for conducting Resident 1 ' s neurocheck after Resident 1 ' s fall on [DATE]. LVN1 the assessment for 5:30 PM was missing, and that LVN1 was busy passing out medications to other residents. LVN 1 stated she should have conducted Resident 1 ' s 5:30 PM neuro check, especially since LVN1 was aware Resident 1 was on three anticoagulation medications and just sustained a fall. During a concurrent interview and record review of Resident 1 ' s medication administration record (MAR) for [DATE], on [DATE] at 2:45 PM, the MAR indicated Resident 1 was prescribed Apixaban 2.5mg PO BID (two times a day at 9 AM and 5 PM) and Resident 1 required to be monitored for bleeding. LVN 1 stated administering Resident 1 ' s dose of Apixaban at 5:10 PM. LVN1 stated at approximately 5:40 PM, FM 2 came out of Resident 1 ' s room, requesting for help because Resident 1 was nonresponsive with his eyes closed, and upper and lower extremities were shaking. During a follow up interview on [DATE] at 3:50 PM with RN1, RN1 stated on [DATE], Resident 1 was observed lying on the floor at approximately 3:45PM after CNA2 called for assistance. RN1 stated Resident 1 was on the floor, in a right-side lying position and Resident 1 ' s head was at the foot of the bed. Resident 1 was unclothed, with diapers (briefs) pulled halfway down that had bowel movement in the diaper. RN1 stated Resident 1 was still able to follow simple commands but was confused. RN 1 stated Resident 1 had a 2x2 bump to the left side of the forehead, and that after Resident 1 was assessed, Resident 1 was placed back into bed. RN1 stated notifying Resident 1 ' s FM and physician and applied an ice back to the bump on Resident 1 ' s forehead. RN1 stated at approximately 5:30 PM on [DATE], after being administered Resident 1 ' s 5 PM scheduled dose of Apixaban, RN1 was called by CNA1 and licensed vocational nurse (LVN) who were in Resident 1 ' s room. RN1 stated once entering Resident 1 ' s room, Resident 1 was observed continuously being startled while unresponsive. RN1 stated Resident 1 was continuously shaking and RN1 could not obtain Resident 1 ' s VS. RN1 stated Resident 1 was transferred to the GACH on [DATE] at approximately 6:15 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 12:45 PM with the facility ' s Pharmacist Consultant (PHARM 1), PHARM 1 stated when residents were prescribed and administered three (3) anticoagulation medications, residents were at high risk for bleeding. PHARM 1 stated Resident 1 was at risk for internal bleeding after his fall with a head injury. During an interview on [DATE] at 2 PM with the DON, the DON stated on Resident 1 ' s electronic medical record, prompts would automatically populate that indicated a drug-to-drug interaction, due to Resident 1 being prescribed multiple anticoagulation medications. The DON stated the prompts were a warning to the medication nurse that Resident 1 was at risk for bleeding. During a concurrent interview and record review of Resident 1 ' s progress notes on [DATE] at 2 PM with the Director of Nursing (DON), DON stated there were several drug to drug interaction warning regarding the three anticoagulation medications (Apixaban 2.5mg PO BID (9 AM & 5 PM), Aspirin 81mg PO Daily and Plavix 75mg PO Daily) with a severity level of severe indicating that the medication may enhance the anticoagulation effects when all 3 medications were taken together. DON stated this warning was to inform the medication nurse that Resident 1 had the potential for bleeding and altered level of consciousness (ALOC: a change in a patient's state of awareness (ability to relate to self and the environment) and arousal (alertness). DON stated that LVN 1 should have contacted MD 1 on [DATE] regarding Resident 1 ' s afternoon 5PM dose of Apixaban prior to administering the medication to Resident 1, knowing Resident 1 sustained a fall on [DATE] at approximately 3:45 PM. During a telephone interview on [DATE] at 8 AM with CNA 2, CNA 2 stated that she heard yelling coming from Resident 1 ' s room on [DATE] at approximately 3:15 PM. CNA 2 stated when she entered Resident 1 ' s room, Resident 1 was observed on the floor lying on his right side, and face facing the foot of the bed with a bump on the left side of his head. CNA 2 stated she called for help and RN 1 and LVN 2 came into the room. During a telephone interview on [DATE] at 3:41 PM with Medical Director (MD) 2, MD 2 stated when a resident was prescribed three different anticoagulant medications, the resident was at high risk for bleeding internally and externally. MD 2 stated after Resident 1 sustained a fall on [DATE], a CT scan should have been ordered to rule out any internal bleeding, since Resident 1 sustained a head injury with a bump to the left side of the forehead. MD 2 stated withholding of the 5PM dose of Apixaban 2.5mg PO BID should have been done until the CT scan was cleared since there was a risk for bleeding. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555616	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ararat Post Acute	1230 E. Windsor Rd. Glendale, CA 91205

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s P&P titled Response to Falls revised [DATE], the P&P indicated to ensure the facility responds quickly and appropriately to resident falls in a manner that addresses both resident ' s immediate needs and longer-term fall prevention. The P&P indicated resident experiencing the fall will be promptly assessed and treated for injuries. The P&P indicated after each fall, a licensed nurse will complete a post-fall assessment and investigation. The P&P indicated the licensed nurse will notify the attending physician of the fall and implement any new physician orders. The P&P indicated following each resident fall, the Licensed Nurse will complete an incident report and perform a Post-Fall Assessment & Investigation. The P&P indicated the Licensed Nurse will also complete the Neurological Flow Sheet for any un-witnessed fall or witnessed fall with known head injury for 72 hours following the fall. The P& P indicated a Licensed Nurse will: document all falls on the 24-hour report, document notification of physician and responsible party, compete an incident report and a detailed progress note, and complete the Post-Fall Assessment & Investigation, complete Neurological Flow Sheet for 72 hours following an un-witnessed fall or fall with known head injury, document the resident's condition in the resident's medical record every shift for 72 hours and revise resident's Care Plan as necessary. During a review of the facility ' s P&P titled Fall Management Program revised [DATE], the P&P indicated to prevent resident falls and minimize complications associated with falls through the development of a Fall Management Program. The P&P indicated the Nursing Staff will develop a plan of care specific to the resident's needs with interventions to reduce the risk of falls. The P&P indicated the Interdisciplinary Team will routinely review the plan of care at a minimum of quarterly, with a significant change in condition, and post fall. The P&P indicated following a resident's fall, the licensed nurse will complete an incident report and a Post -Fall Assessment & Investigation within 24 hours or as soon as practicable, the Licensed Nurse will review the circumstances of the fall, review the plan of care, implement new interventions as appropriate, and revise the plan as indicated, the IDT-Falls Committee will meet within 72 hours of a fall and the IDT-Falls Committee will review and document: summary of event following a fall, root cause analysis, referrals, as necessary; and interventions to prevent future falls. During a review of the facility ' s P&P titled Neurological Assessment revised [DATE], The P&P indicated the purpose to provide guidelines for the performance of a neurological assessment on residents. The P& P indicated nursing Staff will perform a neurological assessment in the following circumstances: upon Attending Physician order, following an unwitnessed fall, following a fall or other accident/injury involving head trauma; or when indicated by resident's condition and Neurological checks will be performed as follows or otherwise ordered by the Attending Physician: Every 15 minutes for 1 hour, then, every 30 minutes for 1 hour, then, Every hour for 2 hours, then every 4 hours for a combined total of 72 hours. The P&P indicated take temperature, pulse, respirations, blood pressure, intracranial Pressure (ICP): Respirations are increased and shallow with ICP. The P&P indicated Notify the Attending Physician of any change if a resident's neurological status, Early signs of neurologic compromise include changes in the resident's level of consciousness, pupillary activity and report other information in. accordance with Facility policy and professional standards of practice. During a review of the facility ' s P&P titled Care Planning revised [DATE], the P&P indicated the purpose was to ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. The P&P indicated a Licensed Nurse will initiate the Care Plan and updated as indicated for change in condition, onset of new problems and on as needed bases. The P&P indicated the Facility will develop a person-centered Baseline Care Plan for each resident within 48 hours of admission. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s P&P titled Change of Condition Notification revised on [DATE], the P&P indicated to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. The P&P indicated the definition of acute change of condition (ACOC) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. Clinically important means a deviation that, without intervention, may result in complications or death. The P&P indicated the Facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal representative when the resident endures a significant change in their condition\caused by, but not limited to an injury/accident, a significant change in the resident's physical, cognitive, behavioral, or functional status, and a significant change in treatment. During a review of the facility ' s policy and procedure (P&P) titled Medication - Black Box Warning revised [DATE], indicated ensure that residents and Staff are aware of the high-risk factors for medications identified in the Black Box Warning category. The P&P indicated the pharmacy will alert the Facility when a medication ordered falls into the Black Box Warning medication category. Nursing Staff will monitor residents receiving these medications for side effects. A Black Box warning appears on the label of certain prescription medications to alert consumers and health care providers about serious side effects, safety concerns and life-threatening risks concerning medications. The P&P indicated the Licensed Nurse will review the Black Box Warning medication(s) for health risks and will monitor the resident for signs and symptoms of those risks, monitoring will involve periodic planned evaluation of the resident ' s progress toward the therapeutic goals, continued vigilance for adverse consequences, and evaluation of potential adverse consequences as set forth in the Black Box Warning, the Licensed Nurse will document the monitoring parameters in the resident ' s Care Plan, the Licensed Nurse will document signs and symptoms related to monitoring parameters and document any adverse consequences in the nursing progress notes or on the Medication Administration Record (MAR), the Licensed Nurse will inform the Attending Physician of any signs and symptoms related to monitoring parameters and/or any adverse consequences and all documentation related to signs and symptoms or adverse reactions will be maintained in the resident ' s medical record.