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	11/05/2025

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 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. (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 0689 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 observation, interview, and record review, the facility failed to provide a safe and secured environment for Resident 1, who was identified as being at high risk for elopement (when a person with cognitive impairment leaves a safe area, such as a care facility or home, without awareness of potential dangers) and wandering (when a person roams and becomes lost or confused about their location) for one of two sampled residents (Resident 1). The facility failed to: Ensure that facility staff supervise Resident 1 and did not leave the resident unattended in the Activity/Dining Room, which was located adjacent to an exit door. Ensure that Activity Staff (AS) 1 was informed of Resident 1's high risk for elopement and need for monitoring, when Licensed Vocational Nurse (LVN) 1 observed the resident wandering out of her room and left the resident with AS 1 in the Activity Room. 3. Ensure that Resident 1 was continuously monitored and supervised by a facility staff in the Activity Room when AS 1 left the facility at the end of her shift on 10/28/2025 at around 5 PM. As a result of these deficient practices, on 10/28/2025 between the hours of 5 PM to 6 PM, Resident 1 wandered out of the facility unsupervised. Resident 1 was later found the same day, on 10/28/2025, at approximately 6:07 PM, sitting at a bus stop on a busy street 0.4 miles from the facility. Resident 1 was located and returned to the facility by a family member (Responsible Party [RP] 1). Resident 1 was placed at significant risk and exposure from falls, injury from motor vehicular accidents, and extreme weather conditions due to the facility's failure to provide Resident 1 with a safe and secure environment, in accordance with the resident's care plan. Findings: During a review of the facility's Policy and Procedures (P&P) titled Wandering and Elopement revised 8/1/2014, the P&P indicated that resident's risk for elopement and preventative interventions will be documented in the resident's medical record, and will be reviewed and re-evaluated by the IDT upon admission, readmission, quarterly, and upon change of condition according to the RAI (Resident Assessment Instrument- a standardized process that nursing homes use to evaluate a resident's needs and develop an individualized care plan) guidelines. The P&P further indicated that the IDT may consider interventions listed in the Elopement Risk Reduction Approaches for residents identified to be at risk for elopement. During a review of the facility's P&P titled Elopement Risk Reduction Approaches, the P&P indicated As necessary, provide new residents (to the facility, wing, unit, etc.) with additional staff assistance until they are comfortable in their new environment. The P&P further indicated that for residents identified at risk for wandering, facility staff needs to know the following information: i. How to identify and understand the resident's needs. ii. The resident's propensity to wander and the triggering conditions. iii. Recognition of the consequences of limited mobility. iv. The consequences of unsafe wandering, the protocols to follow to minimize successful exiting During a review of Resident 1's admission Record, the record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included multiple fracture (a broken bone) of left side ribs, repeated falls, and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Elopement- Wandering Risk Scale assessment dated [DATE], the Assessment indicated Resident 1 was identified at high risk for wandering/elopement due to forgetful/short attention span, diagnosis of dementia with psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), and a known wanderer, including history of wandering. The Assessment did not indicate any recommendations from the facility's licensed nurse who completed the Elopement- Wandering Risk Scale Assessment. During a review of Resident 1's Care Plan titled At risk for wandering/elopement dated 10/22/2025, the Care Plan indicated the goal was to ensure Resident 1 would remain safe within the facility and free from injury and interventions included the following interventions: 1. Keep environment free from clutter; 2. Monitor resident whereabouts every 1 hour; 3. Redirect resident calmly when attempts to ambulate unassisted occurs. The Care Plan did not include to have all interdisciplinary care team made aware of Resident 1's high risk for elopement and the type of supervision required for Resident 1 to remain safe and secured between hours when no staff was monitoring the resident's whereabouts. During a review of Resident 1's Care Plan titled At risk for falls dated 10/22/2025, the care plan indicated that Resident 1 had cognitive impairment and history of recent falls resulting in rib fracture. The care plan interventions indicated that Resident 1 needs a safe environment including even floor, free from spills and clutters, adequate lighting, an accessible call light, and handrails on walls. During a review of the facility Minimum Data Set (MDS - a resident assessment tool) dated 10/25/2025, the MDS indicated Resident 1 had severely impaired (significantly limits one person's physical