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	12/14/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on interview and record review for two of three sampled residents, the facility failed to ensure: 1. Resident 20 ' s Physician Orders for Life Sustaining Treatment (POLST, a form that contains written medical orders for healthcare professionals regarding specific medical treatment that can or cannot be done at the end-of-life) and Advance Directive (living will, legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity) Acknowledgment Form reflected resident's wishes. 2.Resident 15 ' s POLST and Advance Directive Acknowledgment Form reflected Resident 15 Advance Directive. This deficient practice had the potential to result in misinformation of medical care and treatment and not honoring resident's wishes in cases where the resident and/or responsible party was unable to participate in making healthcare decisions. Findings: 1. During a review of Resident 20 ' s Admission Record indicated the resident was admitted on [DATE] with diagnoses that included pulmonary aspergillosis (fungal lung infection caused by inhaling certain mold spores), acute embolism (a clot that moves through the bloodstream) and thrombosis (a clot in a blood vessel) of left femoral vein (a large blood vessel in the thigh), left tibial vein (deep veins in the lower extremities [legs]), and left peroneal vein (fibular vein that runs on the lateral side of lower extremity), and malignant neoplasm (cancer) of lower lobe, left bronchus or lung. During a review of Resident 20 ' s History and Physical (H&P), dated 12/11/2024, indicated the resident had the capacity to understand and make decisions. During a review of Resident 20 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/7/2024, indicated the resident had intact cognition. During a review of Resident 20 ' s POLST dated 12/11/2024 did not indicate if resident received information about an Advance Directive or if resident had an advance directive on file. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 20 ' s Advance Directive Acknowledgement form dated 12/3/2024 indicated Resident 20 had an Advance Directive. During a review of Resident 20 ' s medical chart on 12/13/2024 at 12:24 PM, indicated no evidence that Advance Directive was formulated. During a concurrent interview and record review of Resident 20 ' s POLST and Advance Directive Acknowledgment form on 12/14/2024 at 3:15 PM, the Social Services Director (SSD) stated he was aware that Resident ' s 20 ' s POLST and Advance Directive Acknowledgment form did not match. SSD stated the POLST should be filled out to its entirety, to know what the resident ' s healthcare decisions and wishes are. SSD stated the POLST should not be left blank. SSD stated he clarified with family on 12/13/2024 regarding Resident 20 ' s Advance Directive and was told resident did not have an advance directive and would like more information to obtain an AD. SSD stated it was important for all documentation like the POLST and Advance Directive to be the same, in the case of an emergency to know what the resident ' s wishes are. During an interview on 12/14/2024 at 5:01 PM, the Director of Nursing (DON) stated resident ' s POLST and Advance Directive Acknowledgment form should indicate resident ' s wishes. The DON stated if the information is not the same, staff should verify and clarify with the family and resident. The DON stated it was important to make sure all documents indicate the same thing so that resident ' s wishes can be followed. 42878 2. During a review of Resident 15 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone),hyperlipidemia(a condition in which there are high levels of fat particles in the blood). During a review of Resident 15 ' s History and Physical Assessment [HPA] dated 7/02/2024, the HPA indicated Resident 15 has the capacity to understand and make medical decisions. During a review of Resident 15 ' s MDS, dated [DATE] indicated Resident 15 ' s cognition was intact. During a review of Resident 15 ' s POLST dated 7/4/2024, the POLST did not indicate if Resident 15 had an Advance directive. During an interview and concurrent record review on 12/13/2024 at 11:58 AM with the Social Services Director (SSD), the SSD stated there was no advance directives or evidence that indicated an Advance Directive acknowledgment form was offered to Resident 15 or the responsible party [RP]. The SSD stated advance directives is completed on admission as part of the resident ' s admission paperwork and it should be in the paper chart to indicate Resident 15 ' s wishes. The SSD stated it was important to get this information, so the facility know what the resident ' s or the RP ' s wishes are in case of an emergency. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure titled Advanced Directives with a revision date of 06/01/2021, indicated to provide residents with the opportunity to make decisions regarding their health care . The admission staff will inform and provide written information to all adult residents concerning the right to accept or refuse medical treatment.

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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	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** 42854 Based on interview and record review, the facility failed to ensure the physician was notified for one of one sampled residents (Resident 18), who refused to receive insulin Lispro injection (a medication that is injected into the skin with a needle to lower the blood sugar level and help keep blood sugar level under control for Resident 18 with diabetes [a group of diseases that result in too much sugar in the blood] complications) on multiple occasions. This deficient practice had the potential for Resident 18 to not receive appropriate care, treatment and/or services and increased the risk for Resident 18 to be hyperglycemic (a condition in which the level of glucose (sugar) in the blood is higher than normal, symptoms include: urinating large amounts of urine, excessive thirst, feeling tired, blurred vision) and suffer from complications of high blood sugar levels such as ketoacidosis (a life-threatening condition that occurs when the body produces too many ketones), kidney failure (failure of the kidney to get rid of toxins and extra fluids, and blindness. Findings: During a review of Resident 18 ' s Admission Record indicated the resident was admitted on [DATE] with diagnoses that included periprosthetic fracture (a broken bone that occurs near or around an orthopedic implant, such as a hip or knee replacement) around internal prosthetic (an artificial device that replaces a missing body part) right knee joint, displaced fracture of base of neck of right femur, and type 2 diabetes mellitus (a long term condition in which the body has trouble controlling blood sugar [BS] and using it for energy) with diabetic retinopathy (complication of diabetes that affects the eyes, caused by damage to the blood vessels in the tissue at the back of the eye [retina]) with macular edema (when blood vessels leak in to a part of the retina called the macula, makes the macula swell, causing blurry vision). During a review of Resident 18 ' s History and Physical (H&P), dated 11/30/2024, indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 18 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/1/2024, indicated the resident had severely impaired cognition. During a review of Resident 18 ' s Order Summary indicated the following prescribed physician orders: On 11/27/2024, physician prescribed Insulin Lispro Injection Solution 100 Unit (unit of measure) per Milliliter (mL, unit of measure) (Insulin Lispro) Inject subcutaneously (injection is given in the fatty tissue, just under the skin) before meals for Diabetes Mellitus (DM), Inject as per sliding scale: if 0 - 150 mg/dL (milligrams per deciliter) = 0 UNIT; 151 - 200 mg/dL = 1 UNIT; 201 - 250 mg/dL = 2 UNIT; 251 - 300 mg/dL = 3 UNIT; 301 - 350 mg/dL = 4 UNIT; 351 - 400 mg/dL = 5 UNIT IF GREATER THEN 400 GIVE 6 UNITS NOTIFY Physician (MD), NOTIFY MD IF BS is less than 60, mg/dL subcutaneously before meals for DM (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/28/2024, physician prescribed Insulin Glargine Solution 100 UNIT/ML Inject 22 unit subcutaneously one time a day for DM (DO NOT MIX WITH OTHER INSULINS) During a review of Resident 18 ' s Medication Administration Record (MAR) from 11/2024 to 12/2024 indicated Resident 18 refused Insulin Lispro on the following occasions: On 11/30/2024 at 5:00 PM, Resident 18 had a BS of 202 mg/dL On 12/3/2024 at 7:00 AM, Resident 18 had a BS of 217 mg/dL On 12/4/2024 at 5:00 PM, Resident 18 had a BS of 234 mg/dL On 12/7/2024 at 7:00 AM, Resident 18 had a BS of 209 mg/dL On 12/7/2024 at 11:30 AM, Resident 18 had a BS of 248 mg/dL On 12/7/2024 at 5:00 PM, Resident 18 had a BS of 171 mg/dL On 12/8/2024 at 11:30 AM, Resident 18 had a BS of 180 mg/dL On 12/9/2024 at 5:00 PM, Resident 18 had a BS of 178 mg/dL On 12/11/2024 at 5:00 PM, Resident 18 had a BS of 180 mg/dL During a review of Resident 18 ' s Progress Notes from 11/2024 to 12/2024 indicated the following: On 11/30/2024 at 5:37 PM, Resident family member (FM) 1 at bedside and resident declined medication three times, risks and benefits explained and FM 1 said, I know, but I don ' t want her to have any insulin this evening. Her BS was low in the afternoon, and I don ' t want her BS to go down again. No insulin, please. Rights honored. On 12/1/2024 at 5:55 PM, Only 1 unit was administered, FM 1 at bedside and declined full dose of 2 units. Risks and benefits explained and FM 1 I know, but I don ' t want her to have 2 units only 1 unit this evening. Her BS was low in the afternoon. I don ' t want her BS to go down. On 12/4/2024 at 4:50 PM, Resident refused 3 times, explained risk and benefit, but continue to refuse, respected resident wishes. On 12/6/2024 at 6:57 AM, Resident refused BS to be checked, FM 1 made aware. On 12/6/2024 at 6:59 AM, Resident refused BS to be checked; informed FM 1 and asked to talk with the resident. The note indicated FM 1 asked to pass for now for BS check until FM 1 comes to see resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/6/2024 at 11:37 AM, received report from night shift, resident declined BS check and ordered insulin could not be given. The note indicated FM 1 approached the nursing station and requested for Insulin Glargine to be given. The note indicated the medication nurse explained the situation to FM 1, BS checked to be 195 mg/dL and FM 1 insisted Insulin Glargine to be given at this time because Resident 18 missed it in the morning. The note indicated medication nurse made FM 1 aware that the MD would be communicated and made aware, awaiting MD ' s response. On 12/6/2024 at 4:02 PM, FM 1 was made aware that MD has not given any order per the requested Insulin Glargine. FM 1 said okay that means resident wouldn ' t be having it again today. never mind again. The note indicated no response was received from MD and was endorsed to the next shift. On 12/7/2024 at 5:28 PM, FM 1 was at Resident ' s bedside and decline medication 3 times, risks and benefits explained, verbalized understanding, but declined medication. On 12/9/2024 at 4:40 PM, Resident refused three times, explained risks and benefit but continued to refuse. On 12/11/2024 at 4:56 PM, Resident refused three times, explained risk and benefit, but continued to refuse. During a concurrent interview and record review of Resident 18 ' s MAR from 11/2024 to 12/2024 on 12/14/2024 at 2:28 PM, the Minimum Data Set Registered Nurse (MDS RN), verified Resident 18 refused Insulin Lispro on: 11/30/2024 at 5 PM, 12/3/2024 at 7AM, 12/4/2024 at 5PM, 12/7/2024 at 7AM, 11:30 AM, and 5PM, 12/8/2024 at 11:30 AM, 12/9/2024 at 5:00 PM, and 12/11/2024 at 5:00 PM. During a concurrent interview and record review of Resident 18 ' s Progress notes from 11/2024 to 12/2024 on 12/14/2024 at 2:32 PM, the MDS RN stated she could not find documented evidence of notification to Resident 18 ' s physician regarding resident ' s refusal to take Insulin Lispro. MDS RN stated staff should inform the physician that Resident 18 was refusing Insulin, to better plan resident ' s care and communicate with the interdisciplinary team. During an interview with the Director of Nursing (DON) on 12/14/2024 at 4:55 PM, the DON stated the staff was supposed to notify the physician if a resident refuses medication like Insulin. The DON stated it was important to notify the physician so that the physician can give new orders or add something else in Resident 18 ' s care plan. The DON stated resident refusal to receive insulin was considered a significant change in condition and should be documented in progress notes to include the physician notification. The DON stated a care plan should have been initiated for Resident 18 ' s refusal to take Insulin. During a review of the facility ' s policy and procedure (P&P) titled Refusal of Treatment, dated 10/1/2017 indicated the charge nurse or DON will document information relating to the refusal/discontinuance in the resident ' s medical record that will include at least the date and time the Attending Physician was notified and his or her response. The P&P indicated the Attending Physician will be notified of refusal or discontinuance of treatment in a time frame determined by the resident ' s condition and potential serious consequences of the refusal or discontinuance.

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Ararat Post Acute	1230 E. Windsor Rd. Glendale, CA 91205

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on interview and record review, the facility failed to develop a care plan that included for one of one sampled resident (Resident 18), that indicated alternative interventions were implemented for refusal receive insulin Lispro injection (a medication that is injected into the skin with a needle to lower the blood sugar level and help keep blood sugar level under control for Resident 18 with diabetes [a group of diseases that result in too much sugar in the blood] complications) on multiple occasions. As a result, Resident 18 ' s blood sugar remained high which can result in complications such as high blood sugar levels such as ketoacidosis (a life-threatening condition that occurs when the body produces too many ketones), kidney failure (failure of the kidney to get rid of toxins and extra fluids, and blindness. Cross Reference to F580 Findings: During a review of Resident 18 ' s Admission Record indicated the resident was admitted on [DATE] with diagnoses that included periprosthetic fracture (bone fracture) around internal prosthetic (an artificial device that replaces a missing body part) right knee joint, displaced fracture of base of neck of right femur, and type 2 diabetes mellitus (a long term condition in which the body has trouble controlling blood sugar [BS] and using it for energy) with unspecified diabetic retinopathy (complication of diabetes that affects the eyes, caused by damage to the blood vessels in the tissue at the back of the eye [retina]) with macular edema (when blood vessels leak in to a part of the retina called the macula, makes the macula swell, causing blurry vision). During a review of Resident 18 ' s History and Physical (H&P), dated 11/30/2024, indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 18 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/1/2024, indicated the resident had severely impaired cognition. During a review of Resident 18 ' s Order Summary indicated the following prescribed physician orders: On 11/27/2024, physician prescribed Insulin Lispro Injection Solution 100 Unit (unit of measure) per Milliliter (mL, unit of measure) (Insulin Lispro) Inject subcutaneously (injection is given in the fatty tissue, just under the skin) before meals for Diabetes Mellitus (DM), Inject as per sliding scale: if 0 - 150 = 0 UNIT; 151 - 200 = 1 UNIT; 201 - 250 = 2 UNIT; 251 - 300 = 3 UNIT; 301 - 350 = 4 UNIT; 351 - 400 = 5 UNIT IF GREATER THEN 400 GIVE 6 UNITS NOTIFY Physician (MD), NOTIFY MD IF BS is less than 60, subcutaneously before meals for DM On 11/28/2024, physician prescribed Insulin Glargine Solution 100 UNIT/ML Inject 22 unit subcutaneously one time a day for DM (DO NOT MIX WITH OTHER INSULINS) (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 - Few	During a review of Resident 18 ' s Medication Administration Record (MAR) from 11/2024 to 12/2024 indicated Resident 18 refused Insulin Lispro on the following occasions: On 11/30/2024 at 5:00 PM, Resident 18 had a BS of 202 mg/dL On 12/3/2024 at 7:00 AM, Resident 18 had a BS of 217 mg/dL On 12/4/2024 at 5:00 PM, Resident 18 had a BS of 234 mg/dL On 12/7/2024 at 7:00 AM, Resident 18 had a BS of 209 mg/dL On 12/7/2024 at 11:30 AM, Resident 18 had a BS of 248 mg/dL On 12/7/2024 at 5:00 PM, Resident 18 had a BS of 171 mg/dL On 12/8/2024 at 11:30 AM, Resident 18 had a BS of 180 mg/dL On 12/9/2024 at 5:00 PM, Resident 18 had a BS of 178 mg/dL On 12/11/2024 at 5:00 PM, Resident 18 had a BS of 180 mg/dL During a review of Resident 18 ' s Progress Notes from 11/2024 to 12/2024 indicated the following: On 11/30/2024 at 5:37 PM, Resident family member (FM) 1 at bedside and resident declined medication three times, risks and benefits explained and FM 1 said, I know, but I don ' t want her to have any insulin this evening. Her BS was low in the afternoon, and I don ' t want her BS to go down again. No insulin, please. Rights honored. On 12/1/2024 at 5:55 PM, Only 1 unit was administered, FM 1 at bedside and declined full dose of 2 units. Risks and benefits explained and FM 1 I know, but I don ' t want her to have 2 units only 1 unit this evening. Her BS was low in the afternoon. I don ' t want her BS to go down. On 12/4/2024 at 4:50 PM, Resident refused 3 times, explained risk and benefit, but continue to refuse, respected resident wishes. On 12/6/2024 at 6:57 AM, Resident refused BS to be checked, FM 1 made aware. On 12/6/2024 at 6:59 AM, Resident refused BS to be checked; informed FM 1 and asked to talk with the resident. The note indicated FM 1 asked to pass for now for BS check until FM 1 comes to see resident. On 12/6/2024 at 11:37 AM, received report from night shift, resident declined BS check and ordered insulin could not be given. The note indicated FM 1 approached the nursing station and requested for Insulin Glargine to be given. The note indicated the medication nurse explained the situation to FM 1, BS checked to be 195 mg/dL and FM 1 insisted Insulin Glargine to be given at this time because Resident 18 missed it in the morning. The note indicated medication nurse made FM 1 aware that the MD would be communicated and made aware, awaiting MD ' s response. (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 - Few	On 12/4/2024 at 4:50 PM, Resident refused 3 times, explained risk and benefit, but continue to refuse, respected resident wishes. On 12/6/2024 at 6:57 AM, Resident refused BS to be checked, FM 1 made aware. On 12/6/2024 at 6:59 AM, Resident refused BS to be checked; informed FM 1 and asked to talk with the resident. The note indicated FM 1 asked to pass for now for BS check until FM 1 comes to see resident. On 12/6/2024 at 11:37 AM, received report from night shift, resident declined BS check and ordered insulin could not be given. The note indicated FM 1 approached the nursing station and requested for Insulin Glargine to be given. The note indicated the medication nurse explained the situation to FM 1, BS checked to be 195 and FM 1 insisted Insulin Glargine to be given at this time because Resident 18 missed it in the morning. The note indicated medication nurse made FM 1 aware that the MD would be communicated and made aware, awaiting MD ' s response. On 12/6/2024 at 4:02 PM, FM 1 was made aware that MD has not given any order per the requested Insulin Glargine. FM 1 said okay that means resident wouldn ' t be having it again today. never mind again. The note indicated no response was received from MD and was endorsed to the next shift. On 12/7/2024 at 5:28 PM, FM 1 was at Resident ' s bedside and decline medication 3 times, risks and benefits explained, verbalized understanding, but declined medication. On 12/9/2024 at 4:40 PM, Resident refused three times, explained risks and benefit but continued to refuse. On 12/11/2024 at 4:56 PM, Resident refused three times, explained risk and benefit, but continued to refuse. During a concurrent interview and record review of Resident 18 ' s MAR from 11/2024 to 12/2024 on 12/14/2024 at 2:28 PM, the Minimum Data Set Registered Nurse (MDS RN), verified Resident 18 refused Insulin Lispro on: 11/30/2024 at 5:00 PM, 12/3/2024 at 7:00 AM, 12/4/2024 at 5:00 PM, 12/7/2024 at 7:00 AM, 11:30 AM, and 5:00 PM, 12/8/2024 at 11:30 AM, 12/9/2024 at 5:00 PM, and 12/11/2024 at 5:00 PM. During a concurrent interview and record review of Resident 18 ' s Progress notes from 11/2024 to 12/2024 on 12/14/2024 at 2:28 PM, the MDS RN could not find documented evidence of a plan of care that addressed Resident 18 ' s refusal to take Insulin Lispro. MDS RN stated staff should inform the physician that Resident 18 was refusing Insulin, to better plan resident ' s care and communicate with the interdisciplinary team. During an interview with the Director of Nursing (DON) on 12/14/2024 at 4:55 PM, the DON stated she expects her staff to notify the physician if a resident refuses medication like Insulin. The DON stated it was important to notify the physician so that the physician can give new orders or add something else in Resident 18 ' s care plan. The DON stated a care plan should have been initiated for Resident 18 ' s refusal to take Insulin. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled Refusal of Treatment, dated 10/1/2017 indicated the Interdisciplinary Team will assess the resident ' s needs, and offer the resident alternative treatments while continuing to provide other services in the Care Plan. The P&P indicated when the resident ' s refusal or discontinuance brings about a significant change in the resident ' s condition, a reassessment is made, and new information is incorporated into the resident ' s Care Plan.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on observation, interview and record review the facility failed to ensure medically related social services were provided to one of two (Resident 11) sampled residents, in accordance with the facility ' s policy and procedure titled Social Services Program, when the Social Services Director [SSD] by failing to follow-up or assist when Resident 11's representative requested for additional information about the Advance Directive (AD- A legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions). These deficient practices led to a delay in receiving AD information as requested by Resident 11 and the Responsible Party from the facility that could result in the resident not to receive the healthcare needed in an event of an emergency where the resident and/or responsible party was unable to participate in making healthcare decisions. Findings: During a review of Resident 11 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated the resident was readmitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing foods or liquids), unspecified dementia (loss of memory, language, problem solving and other thinking abilities). During a review of Resident 11 ' s History and Physical [H&P] dated 3/15/2024, the H&P indicated the resident was not able to make her own decisions. During a review of Resident 11 ' s Physicians Order of Life Sustaining Treatment(POLST) dated 12/04/2020, the POLST indicated the resident did not have an Advance Directive. During a review of Resident 11 ' s Advance Healthcare Directive Acknowledgement form dated 3/1/2023, was signed by Resident 11 ' s Responsible Party (RP1) and indicated Resident 11 did not have an Advance Directive and would like to receive more information. During a review of facility provided list titled Advanced Directives Request for Ombudsman, Resident 11 ' s name was not observed in the list. During a concurrent interview and record review of Resident 11 ' s medical chart with the Social Services Director (SSD) on 12/13/2024 at 11:52 AM, the SSD stated his responsible to assists with resident admissions with the Admission Coordinator and licensed nurses. The SSD stated he explains the forms to all the Residents and their representatives on admission. SSD stated when a Resident or Resident Representative marks that they would like more information on Advance Directives on the Advance Directive Acknowledgement form, he calls the Ombudsman to coordinate a visit between Ombudsman and the family to ensure their questions of how to create and Advance Directive were addressed by the Ombudsman. SSD stated he had not referred Resident 11 ' s RP to the Ombudsman as he was unaware, they had requested more information with the previous SSD. (continued on next page)

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	555616	A. Building B. Wing	12/14/2024

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

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 12/14/2024 at 4:34 PM with Resident 11 ' s Representative (RP 1), RP 1 stated she had requested more information regarding Advance directive over a year ago from SSD, but no one had followed up. RP 1 stated the facility has had a few different SSD since her initial request and she had followed up this year with the previous SSD but never got a response. During a review of facility ' s P&P titled Social Services Program revised on June 01, 2021, the P&P indicated Medically related social services are provided to residents in order to maintain and improve the resident ' s wellbeing.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on interview and record review the facility failed to follow physician ' s orders for one of one sampled resident (Resident 18) who was receiving Insulin (medication that helps keep blood sugar under control and prevents diabetes [a group of diseases that result in too much sugar in the blood] complications). This deficient practice increased the risk of Resident 18 to experience adverse effects (unwanted and dangerous side effects of medication) that could lead to health complications, such as hyperglycemia (a condition in which the level of glucose (sugar) in the blood is higher than normal, symptoms include: urinating large amounts of urine, excessive thirst, feeling tired, blurred vision) Findings: During a review of Resident 18 ' s Admission Record indicated the resident was admitted on [DATE] with diagnoses that included periprosthetic fracture (bone fracture) around internal prosthetic (an artificial device that replaces a missing body part) right knee joint, displaced fracture of base of neck of right femur, and type 2 diabetes mellitus (a long term condition in which the body has trouble controlling blood sugar [BS] and using it for energy) with unspecified diabetic retinopathy (complication of diabetes that affects the eyes, caused by damage to the blood vessels in the tissue at the back of the eye [retina]) with macular edema (when blood vessels leak in to a part of the retina called the macula, makes the macula swell, causing blurry vision). During a review of Resident 18 ' s History and Physical (H&P), dated 11/30/2024, indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 18 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/1/2024, indicated the resident had severely impaired cognition. During a review of Resident 18 ' s Order Summary indicated the following prescribed physician orders: On 11/27/2024, physician prescribed Insulin Lispro Injection Solution 100 Unit (unit of measure) per Milliliter (mL, unit of measure) (Insulin Lispro) Inject subcutaneously (injection is given in the fatty tissue, just under the skin) before meals for Diabetes Mellitus (DM), Inject as per sliding scale: if 0 - 150 = 0 UNIT; 151 - 200 = 1 UNIT; 201 - 250 = 2 UNIT; 251 - 300 = 3 UNIT; 301 - 350 = 4 UNIT; 351 - 400 = 5 UNIT IF GREATER THEN 400 GIVE 6 UNITS NOTIFY Physician (MD), NOTIFY MD IF BS is less than 60, subcutaneously before meals for DM On 11/28/2024, physician prescribed Insulin Glargine Solution 100 UNIT/ML Inject 22 unit subcutaneously one time a day for DM (DO NOT MIX WITH OTHER INSULINS) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 18 ' s Progress Notes on 12/1/2024 timed at 5:55 PM indicated only 1 unit was administered, Resident 18 ' s Family Member (FM) 1 at bedside and declined full dose of 2 units. Risks and benefits explained and FM 1 I know, but I don ' t want her to have 2 units only 1 unit this evening. Her BS was low in the afternoon. I don ' t want her BS to go down. During a concurrent interview and record review of Resident 18 ' s Progress notes on 12/14/2024 at 2:28 PM, the MDS RN stated the progress note dated 12/1/2024 timed at 5:55 PM indicated the nurse did not give Insulin as ordered by the physician. The MDS RN stated the nurse should have not given the medication. During an interview with the Director of Nursing (DON) on 12/14/2024 at 4:55 PM, the DON stated she expects her staff to always follow the physician orders. The DON stated it was important for staff to follow physician orders to ensure there would not be any negative reaction. During a review of the facility ' s policy and procedure (P&P) titled Medication Administration, dated 7/1/2016 indicated medication will be administered by a licensed nurse per the order of an Attending Physician or licensed independent practitioner. The P&P indicated the Rule of 3 the licensed nurse administering medications will perform 3 checks comparing the physician ' s order, pharmacy label, and medication administration record (MAR).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on observation, interview, and record review the facility failed to follow proper sanitation and safe food handling in accordance with the facilities policy and procedure by failing to ensure: 1. Rotten plums were not kept in the food supply for residents and stored in the plastic container in kitchen walk in refrigerator. 2. A half full box of Kale vegetable was discarded as indicated in the label to with discard date 12/9/2024. 3. A plastic bag with five Danishes were kept sealed in the freezer with used by date 12/11/24. 4. A sliced can of apple was discard as indicated in the label to be discarded on [DATE] These deficient practices had the potential to place residents at risk for foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). Findings: On 12/12/2024 at 9:30 AM, during an initial observation of the kitchen refrigerator with Dietary Supervisor a plastic container containing plums was observed in the walk-in refrigerator with 2 rotten plums and a carton box with kale half full labeled with discard date of 12/9/2024. On 12/12/2024 at 9:35 AM, there was an observation of the facilities walk in freezer of an opened clear plastic bag half full the bag was labeled as Danishes with a use by date of 12/11/2024. During a subsequent observation and interview on 12/12/2024 at of the kitchen dry storage area rack where canned food is stored there was an observation of a metal can containing sliced apples with a label On 12/12/2024 at 9:50 AM during a subsequent interview with Dietary Supervisor, DS stated all staff should be checking the refrigerator every morning for spoiled food and produce. DS stated spoiled plums, kale and Danishes found in freezer should have been discarded by the discard date or once they were observed to be spoiled in the morning when the refrigerator is checked. DS stated cans such as the sliced apple can with discard date of September should be removed from can storage on the discard date to prevent them from being served and possibly making the residents sick and prevent any food borne illness to the residents.

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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** 42854 Based on observation, interview, and record review, the facility failed implement the policy and procedure for infection control by ensuring resident care equipment utilized for residents was sanitary, labeled and properly stored for eight of 8 sampled residents: For Residents 20 and 70 cloth gait belts (safety device used to help people move around safely, especially when they are at risk of falling) were inside the restroom. For Residents 2,3,5,9,11 and 15.the cloth gait belts were inside the restroom that any resident could readily access. This deficient practice had the potential for the residents to share resident care equipment, which can spread infection and cross contamination (transfer disease causing organism) to other residents. Findings: 1a. During a review of Resident 70 ' s Admission Record indicated the resident was admitted on [DATE] with diagnoses that included periprosthetic fracture (a broken bone that occurs near or around a hip or knee replacement) around internal prosthetic (an artificial device that replaces a missing body part) left knee joint, repeated falls, and muscle weakness. During a review of Resident 70 ' s History and Physical (H&P), dated 12/11/2024, indicated the resident did not have the capacity to understand and make decisions. During a concurrent observation and interview in Resident 70 ' s room on 12/12/2024 at 11:50 AM, a soiled cloth gait belt with no resident name was observed in the resident restroom. Resident 70 ' s Family Member (FM) 1 stated Resident 70 had a roommate when she was admitted to facility but does not share a room with anyone at the moment. FM 1 stated Resident 70 does not use the restroom. FM 1 stated she was not sure who the belt belonged to. During a concurrent observation and interview in Resident 70 ' s room on 12/12/2024 at 12:15 PM, Registered Nurse (RN) 1 confirmed soiled cloth gait belt was in Resident 70 ' s restroom with no resident name. RN 1 stated the cloth gait belt did not belong to Resident 70 and must have been for someone else. 1b. During a review of Resident 20 ' s Admission Record indicated the resident was admitted on [DATE] with diagnoses that included pulmonary aspergillosis (fungal lung infection caused by inhaling certain mold spores), acute embolism (a clot that moves through the bloodstream) and thrombosis (a clot in a blood vessel) of left femoral vein (a large blood vessel in the thigh), left tibial vein (deep veins in the lower extremities [legs]), and left peroneal vein (fibular vein that runs on the lateral side of lower extremity), and malignant neoplasm (cancer) of lower lobe, left bronchus or lung. During a review of Resident 20 ' s History and Physical (H&P), dated 12/11/2024, indicated the resident had the capacity to understand and make decisions. (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 20 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/7/2024, indicated the resident had intact cognition. During an observation in Resident 20 ' s room on 12/12/2024 at 11:53 AM, a cloth gait belt labeled Rehab was observed in the resident restroom. During a concurrent observation and interview in Resident 20 ' s room on 12/12/2024 at 12:18 PM, Infection Prevention Nurse (IPN) confirmed cloth gait belt labeled Rehab was in Resident 20 ' s restroom. IPN stated the cloth gait belt belonged to the Rehab department. IPN stated the gait belt was being sanitized. 2a. During a review of Resident 15 ' s Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), hyperlipidemia (a condition in which there are high levels of fat particles in the blood). During a review of Resident 15 ' s History and Physical Assessment, dated 7/2/2024, indicated Resident 15 has the capacity to understand and make medical decisions. During a review of Resident 15 ' s Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 9/16/2024 indicated Resident 15 ' s cognition (ability to think and reason) was intact. During a review of Resident 3 ' s Face Sheet, indicated the resident was admitted to the facility on [DATE] with diagnoses that included Type 2 diabetes mellitus (high levels of sugar in the blood) with diabetic neuropathy (a complication of diabetes that damages nerves in the body),Hypertensive heart disease (a group of heart conditions that occurs when high blood pressure is left unmanaged over a long period of time). During a review of Resident 3 ' s History and Physical Assessment, dated 3/23/2024, the HPA indicated Resident 3 has the capacity to understand and make medical decisions. During a review of Resident 3 MDS, dated [DATE], indicated Resident 15 ' s cognition was intact. During an observation on 12/12/24 at 11:47 AM of Resident 15 ' s and 3 ' s shared restroom there was a cloth gait belt with no resident name was observed inside the resident restroom hanging from a metal hook attached to the door. During a concurrent observation and interview in Resident 15 ' s and 3 ' s restroom on 12/12/2024 at 11:55 AM, Registered Nurse (RN) 1 confirmed soiled cloth gait belt was in Resident 15 ' s and 3 ' s shared restroom with no resident name. RN 1 stated she believed the cloth gait belt belonged to Resident 3 but was unsure as there was no name on the gait belt. 2b. During a review of Resident 2 ' s Face Sheet, indicated the resident was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease (a long term condition where the kidneys are damaged) and Type 2 Diabetes mellitus (high levels of sugar in the blood). During a review of Resident 2 ' s History and Physical Assessment [HPA] dated 1/12/2024, the HPA indicated Resident 2 does not have the capacity to understand and make decisions. (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 2 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/7/2024, indicated the resident had intact cognition. During a review of Resident 9 ' s Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included polyneuropathy (a disease affecting the nerves outside the brain and spinal cord), rheumatoid arthritis (a chronic inflammatory disorder usually affecting small joints in the hands and feet) During a review of Resident 9 ' s History and Physical Assessment [HPA] dated 2/15/2024, the HPA indicated Resident 9 does not have the capacity to understand and make decisions. During a review of Resident 9 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/12/2024, indicated the resident had moderately impaired cognition. During a review of Resident 11 ' s Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing foods or liquids), unspecified dementia (loss of memory, language, problem solving and other thinking abilities). During a review of Resident 11 ' s History and Physical [H&P] dated 3/15/2024, the H&P indicated the resident was not able to make her own decisions. During a review of Resident 5 ' s Face Sheet indicated the resident was readmitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing foods or liquids), chronic kidney disease stage 3 (a moderate level of kidney damage that results in reduced kidney function). During a review of Resident 5 ' s History and Physical [H&P] dated 2/21/2024, the H&P indicated the resident does not have the capacity to understand and make her own decisions. During an observation on 12/12/24 at 12:00 PM of Resident 2,9,11 and 5 ' s shared restroom there was a cloth gait belt with no resident name was observed inside the resident restroom hanging from a metal hook attached to the door. . During a concurrent observation and interview in Resident ' s 2, 9,11 and 5 ' s room on 12/12/2024 at 12:05 PM with Certified Nursing Assistant (CNA 1), CNA 1 stated she will use the cloth gait belt for Resident ' s 2 and 11. CNA 1 stated she was not instructed how to clean the gait belt sometimes she would wipe it down with a wipe in between resident uses but the cloth gait belt was shared for the resident ' s in that room. During a concurrent interview and observation of Resident 2, 9, 11 and 5 shared restroom on 12/12/2024 at 12:08 PM with Infection Prevention Nurse (IPN) , IPN stated there was no identifier in the cloth gait belt in the restroom and gait cloth gait belts should not be shared among different residents as there was no way to properly clean them in between residents use. IPN stated each Resident should have their won personal cloth gait belt labeled with their name and be kept next to residents' bedside. (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 interview with the Director of Nursing (DON) on 12/14/2024 at 4:59 PM, the DON stated there was no way to sanitize cloth gait belts. The DON stated all cloth gait belts were removed from resident restrooms and plastic gait belts were ordered to sanitize the gait belts when used between patients. The DON stated it was important to disinfect the gait belts after each use for infection control. During a review of the facility ' s policy and procedure (P&P) titled Cleaning & Disinfection of Resident Care Equipment, dated 5/1/2017 indicated resident- care equipment, including reusable items and durable medical equipment is cleaned and disinfected per current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard.