

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555616	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Ararat Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on observation, interview, and record review, the facility failed to ensure to store, prepare, distribute and serve food for all the 24 residents in the facility receiving food from the kitchen in accordance with professional standards for food service safety, and the facility's policy and procedure titled, Food Storage, dated 11/1/2014. This deficient practice had the potential for the residents to acquire food-borne illnesses (a life threatening infection due to consuming contaminated food) from ingesting expired food. Findings: During an initial tour of the facility's kitchen on 1/20/2026 at 8:35 AM with the Dietary Manager (DM) there were undated and expired food items stored in the refrigerator: Undated uncooked celery stored in a box. Expired cabbage stored in a refrigerator with a label to use by 1/16/2026. During a concurrent observation and interview on 1/20/2026 at 8: 35 with the Dietary Manager (DM) stated that all kitchen stored food is labeled and someone must have forgotten to label the celery. DM stated that the cabbage was not going to be used and that someone must have forgotten to throw it away. During an interview on 1/21/2026 with Dietary Supervisor (DS) stated that all food that is expired gets thrown away immediately and the cabbage must have been left behind by accident. During a review of the facility's policy and procedure titled, Food Storage, dated 11/1/2014, indicated, that all food items will be stored, thawed and prepare in accordance with good sanitary practice.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement infection control practices in accordance with the facility's policy and procedure by failing to: 1.Ensure a humidifier bottle (a small bottle attached to the oxygen tubing that holds water to keep oxygen from drying out a person's nose and lungs) was changed for one of six sampled residents (Resident 26) reviewed for infection control that required oxygen therapy in accordance with the facility's policy and procedure (P&P) titled Oxygen administration. 2. Ensure the staff were using a gown while assisting the resident that was on enhanced barrier precaution (EBP- an infection control measures that involve wearing gowns and gloves for all high-contact activities with residents in nursing homes to stop the spread of multidrug-resistant organism [MDRO- is a type of bacteria that has developed resistance to multiple antibiotics, making infections difficult to treat and requiring enhanced infection prevention measures to reduce transmission]) for 1 of 6 sampled residents (Resident 6) reviewed for infection control. These failures had the potential for the residents to be at increased risk of infection and transmission of infection to other residents, staff and visitors that could result in a wide spread of infection in the facility. Findings: 1. During a review of Resident 26's admission Record (AR), the AR indicated the facility admitted Resident 26 on [DATE] with diagnoses that included but not limited to hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (one-sided muscle weakness caused by a disruption of the brain, spinal cord, or nerves connected to the affected muscles) following cerebral infarction (part of the brain didn't get enough blood and oxygen, so brain cells were damaged or died) affecting left non-dominant side, muscle weakness, and atrial fibrillation (an irregular heartbeat where the heart beats fast and unevenly instead of steady and strong). During a review of Resident 26's physician's order, dated [DATE], the order indicated Resident 26 to receive continuous oxygen at two liters per minute (LPM), keep oxygen saturation (how much oxygen the blood is carrying) above 92 percent. During a review of Resident 26's Minimum Data Set (MDS- a resident assessment tool) dated [DATE], the MDS indicated Resident 26 had severely impaired cognition (ability to think, reason, and function). The MDS indicated Resident 26 was dependent on helpers for toileting and personal hygiene. During an observation on [DATE] at 9:49 AM in Resident 26's room, Resident 26 observed in bed on oxygen at 2 LPM connected to a humidifier bottle labeled [DATE]. During a concurrent observation and interview on [DATE] at 10:52 AM with Treatment Nurse (TX) 1 inside Resident 26's room, TX 1 stated the humidifier bottle was dated [DATE] and should have been changed when the oxygen tubing was changed which was labeled [DATE]. TX 1 stated, oxygen tubing and humidifier bottles were changed every Sunday mainly for infection control by preventing harboring of bacteria. During an interview on [DATE] at 10:46 with the Director of Nursing (DON), the DON stated, humidifier bottles and oxygen tubing should be changed every Sunday by the night shift licensed nurses and should be labeled by writing the date it was changed on the humidifier bottle. The DON stated humidifier bottles should be changed every Sunday for infection control, to prevent growth of bacteria in the water that can make residents sick. During a review of the facility's P&P titled, Oxygen administration, revised 8/2014, the P&P indicated, All oxygen tubing, humidifiers, masks, and cannulas used to deliver oxygen will be changed weekly and when visibly soiled. 2. During a review of Resident 6's admission Record (AR), the AR indicated the facility admitted Resident 6 on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to neuromuscular dysfunction of bladder (a condition in which impaired nerve and muscle coordination affects the bladder's ability to store or empty urine appropriately), benign prostatic hyperplasia with lower urinary tract symptoms (an overgrowth of the prostate tissue that pushes against the urethra and the bladder, blocking the flow of urine), and retention of urine. During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool) dated [DATE], the MDS indicated Resident 6 had moderately impaired cognition (ability to think, reason, and function). The MDS indicated Resident 6 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required moderate assistance with toileting hygiene, showering and personal hygiene. During a review of Resident 6's physician's order, dated [DATE], the order indicated Resident 6 had an order for indwelling urinary catheter (a thin, flexible, sterile tube inserted into the bladder to drain urine into a bag outside the body) to gravity drain every shift. During a review of Resident 6's physician order dated [DATE], the order indicated Resident 6 had an order for EBP precaution due to indwelling urinary catheter use. During a review of Resident 6's Care Plan (CP), initiated on [DATE], the CP indicated Resident 26 was on EBP due to indwelling urinary catheter use. The CP goals indicated Resident 26's risk of developing and or transmitting infection would be minimized or reduced. The CP intervention indicated for staff to wear gowns and gloves while performing any care activity where close contact with the resident was expected to occur such as assisting with toileting. During an observation on [DATE] at 9:22 AM in Resident 6's room, EBP precaution signage observed posted outside the door indicated providers and staff must wear gloves and gowns for high-contact resident care activities that included assisting with toileting of residents. Certified Nursing Assistant (CNA) 2 put on gloves but did not wear a gown when CNA 2 assisted Resident 6 to the bathroom who had an indwelling urinary catheter. During an interview on [DATE] at 11:37 AM with CNA 2, CNA 2 stated, I forgot to wear a gown. CNA 2 stated gowns and gloves must be worn when in direct contact with residents on EBP precautions to prevent infection, spread of bacteria to the residents and to the staff. During an interview on [DATE] at 9:02 AM with Registered Nurse (RN) 1, RN 1 stated, proper Personal Protective Equipment (PPE- the gear healthcare workers wear to protect themselves and the patient, like gloves, gowns, masks or face shields to stop germs from spreading) must be used for residents on EBP precautions during direct contact care to prevent spread of any infections and protect high risk residents like those with indwelling urinary catheters from MDROs. During an interview on [DATE] at 10:46 with the Director of Nursing (DON), the DON stated staff, visitors and anybody must wear gowns and gloves when in close contact with residents on EBP precautions to prevent spread of infection to other residents, the staff and the community. During a review of the facility's policy and procedure (P&P) titled, Standard and enhanced precautions dated 4/2024, the P&P indicated, EBP refers to an infection control intervention designed to reduce transmission of MDROs that employs targeted gown and glove use during high contact resident care activities that are associated with a high risk of MDRO colonization when contact precautions do not otherwise apply and/or transmission such as presence of indwelling devices (e.g., urinary catheter.). For residents whom EBP are indicated, EBP should be used when performing high-contact resident care activities such as changing briefs or assisting with toileting.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide privacy and a homelike environment for two of two sampled residents (Resident 29 and Resident 39) by failing to report the missing to the maintenance supervisor to replace the missing horizontal window blind slats in Resident 29 and Resident 39's room. This deficient practice resulted in having a non-homelike environment and a violation of the residents' rights for privacy when the residents were exposed to the other people outside in the walkway and neighboring building near the facility. In addition, the loss of privacy had the potential to affect their psychosocial wellbeing of the residents. Findings: During a review of Resident 29's admission Record, the admission Record indicated the facility originally admitted Resident 29 on 4/30/2024 and readmitted on [DATE] with diagnoses that included heart failure (the heart is unable to pump blood around the body properly), diabetes mellitus (a disease that affects how the body uses blood sugar) and osteoarthritis (chronic joint disease, often called wear-and-tear arthritis) of both knees. During a review of Resident 29's Minimum Data Set (MDS, a Resident assessment tool), dated 11/13/2025, indicated Resident 29's cognition (ability to think and reason) was intact. During a concurrent observation and interview on 1/20/2026 at 9:46 AM with Resident 29 in Resident 29's room, Resident 29's bed was near by the window with opened vertical blinds that had two pieces of slats missing exposing the room from outside walkway and neighboring building. Resident 29 stated, she was not sure who she who she reported the missing slats on the blinds to which has been missing for at least two days. Resident 29 stated, the blinds help with the sun for shade and provides her privacy. 2. During a review of Resident 39's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] , with diagnoses that included congestive heart failure (the heart can't pump enough oxygen-rich blood to meet your body's needs), chronic kidney disease (a long-term condition where the kidneys do not work as well as they should), and diabetes mellitus. During a review of Resident 39's History and Physical (H&P) dated 1/11/2026, the H&P indicated Resident 39 was alert and oriented to place and time. During a review of Resident 39's MDS dated [DATE], indicated the resident's cognitive status was moderately impaired. During a concurrent observation and interview on 1/20/2026 at 9:55 AM with Resident 39 in Resident 39's room, Resident 39's bed was near by the window, with opened vertical blinds that had two pieces of slats missing exposing the room from outside walkway. Resident 29 stated, she was not sure who she reported the missing blinds to which has been missing for at least two days. Resident 29 stated, the blinds help with the sun for shade and provides her privacy. from outside walkway. Resident 39 pointing at the missing vertical blinds, nodded yes when asked if the missing vertical blinds bothers her. During a concurrent observation and interview on 1/20/2026 at 10 AM with Registered Nurse (RN) 3 in Resident 29's room and then Resident 39's room. RN 3 stated both rooms for Residents 29 and 39 were missing window slates on the vertical blinds which exposes the residents from outside walkway, and neighboring building. RN 3 stated, the rooms with missing window vertical blinds slate was not homelike, it could affect residents' comfort and privacy. During an interview on 1/21/2026 at 2:27 PM with the Maintenance Director (MTD), MTD stated, he was not aware of Resident 29 and Resident 39's missing slats on the window blinds. MTD stated, it was probably missed when they check the rooms. MTD stated, it was important to replace the missing blinds right away for Residents comfort (shade from the sun) and privacy. During an interview on 1/21/2026 at 3:10 PM with the Director of Nurses (DON), DON stated, it was not homelike for Resident 29 and Resident 39 to have missing window blinds in their room, it should have been replaced right away. DON stated the missing slats on the window blinds in Resident 29 and 39's room could potentially affect Resident 29 and Resident privacy that may negatively affect their psychosocial wellbeing. A review of the facility's policy and procedure (P&P) titled Resident Rooms and Environment, dated 11/1/2017, the P&P indicated, facility provides residents with safe, comfortable and homelike environment. A review of (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility's policy and procedure (P&P) titled Privacy and Dignity, dated 7/1/2016 indicated, facility promote and/or enhance privacy, dignity and overall quality of life, and facility respect's the resident's private space.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to ensure two of two sampled residents (Resident 39 and Resident 41) and their representatives, reviewed for resident's rights were offered an information regarding Advance Directives (AD a written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) in accordance with facility policy titled Advance Directives and regulatory requirements. This deficient practice has the potential for care and services to not be performed during medical emergencies according to the residents and/or family wishes. 1. During a record review of Resident 41's admission Record (AR) dated 1/17/2026 indicated Resident 41 was admitted on [DATE], with the diagnoses of pneumonia (an infection/inflammation in the lungs), dysphagia (difficulty swallowing), history of malignant neoplasm of the prostate (cancerous tumor that can spread (metastasize) to other parts of the body). During a record review of Resident 41's Initial History & Physical dated 1/20/2026, indicated that Resident 41 has fluctuating capacity to understand and make decisions. During a concurrent interview and record review on 1/21/2026 at 9:50 AM with Social Services Coordinator (SSC), indicated Resident 41's Advance Directive Acknowledgement dated 1/17/2026, was not signed by the responsible party. SSC stated that he understands that AD should had been done when the resident was admitted to the facility to honor residents wishes and preferences, but SSC stated the AD was not completed. During an interview on 1/23/2026 at 1:42 PM with Director of Nurses (DON) stated that the AD was supposed to be initiated upon admission to ensure residents wishes and preferences are followed and to ensure that during medical emergencies residents and Responsible Party (RP) wishes and preferences are followed. ^ ^ 2. During a review of Resident 39's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] , with diagnoses that included congestive heart failure (the heart can't pump enough oxygen-rich blood to meet your body's needs), chronic kidney disease (a long-term condition where the kidneys do not work as well as they should), and diabetes (chronic condition where blood sugar (glucose) levels are too high because the body does not make enough insulin or cannot use it proper). During a review of Resident 39's History and Physical (H&P) dated 1/11/2026, the H&P indicated Resident 39 was alert and oriented to place and time and able to make decisions. During a review of Resident 39's Minimum Data Set (MDS- a resident assessment tool) dated 1/12/2026, indicated the resident cognitive status (level of mental functioning) was moderately impaired. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/20/2026 at 2:56 PM with Registered Nurse (RN) 3, Director of Nurses (DON), and Social Service Coordinator (SSC), Resident 39's physical chart was reviewed. There was no documented evidence in Resident 39's clinical record to indicate that an Advance Directive or acknowledgement of Advance Directive was offered and/or if the resident was informed. DON stated, Advance directive acknowledgement should have been done upon admission, and it should be in Resident 39's physical chart. SSC stated, he was responsible ensuring Resident 39 had an advance directive or an acknowledgement of an advance directive, he stated he must have missed informing the RP about the advance Directive acknowledgement. SSC stated, not having an Advance Directive was important to ensure residents' healthcare wishes and preferred care during medical emergencies were clearly identified, documented, and honored. During an interview on 1/21/2026 at 3:01 PM with the DON, DON stated, Resident 39's Advance Directive should have been initiated upon admission to ensure Resident 39 and/ or family wishes are followed. DON stated, not having an advance directive had the potential for care and services to not be performed during medical emergencies according to the residents and/or family wishes. During a review of the facility's policy and procedure (P&P) titled Advance Directives, dated 6/1/2021, the P&P indicated: a) the facility will honor resident's advance directive and will provide the resident information related to advance directive upon admission, b) upon admission designee will inform the resident their right to execute an advance directive, if one does not already exist. and c) a copy of the advance directive is maintained as part of Resident's medical record.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to implement its policy and procedure to provide the Medicare change status form: Skilled Nursing Facility Advance Beneficiary Notice (SNFABN, notice of liability) and Notice of Medicare Non-Coverage (NOMNC) letters/forms to one of three sampled residents (Residents 45) within two (2) days of the last Medicare part A covered day. This deficient practice had the potential for Resident 45 not to exercise the right to appeal and not be aware of possible charges for services rendered that were not covered after her last Medicare part A coverage day. Findings: During a concurrent interview and record review on 1/23/2026 at 11:41 AM with the social service coordinator (SSC), the facility document notices provided to Resident 45: SNF-ABN date of notice 6/19/2025 and NOMNC dated 6/18/2025 was reviewed. The documents SNF-ABN and NOMNC was signed by Resident 45 on 6/18/2025. SSC stated, he was responsible in providing the notices to resident or responsible party. SSC stated, it is facility's policy to provide the notices to Resident 45 a minimum of 2 days prior to the last day of Medicare part A coverage, and Resident 45 last Medicare Part A covered day was 6/18/2025, which made the notices late. SSC stated providing the notices late, did not give Resident 45 time to appeal the change in medical coverage, and had the potential to incur charges that was no longer covered by Medicare part A. During an interview on 1/23/2026 at 11:50 AM with the Director of Nurses (DON), DON stated, facility document notices SNF-ABN and NOMNC should be provided to the resident a minimum of 2 days prior to the last day of Medicare part A as per policy, to ensure the resident had ample time to make medical coverage decisions, as well as appeal the change of medical coverage. DON stated, Resident 45's SNF-ABN and NOMNC notices was late which did not give Resident 45 time to exercise the right to appeal the change of coverage and potentially can incur charges no longer covered by Medicare part A. A review of the facility's policy and procedure titled, Medicare Denial Process, dated 10/24/2022 indicated: a) Medicare Status Change form maybe completed by designee a minimum of 2 days prior to the last Medicare Part A covered day, and b) the designee prepares and issues the Medicare Status Change which includes SNF-ABN and NOMNC to the beneficiary or representative.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 32) reviewed for pressure ulcer (a skin breakdown due to prolonged unrelieved pressure and skin friction) receives care, consistent with professional standards of practice, to prevent pressure ulcers had recommended inflation/adjustment setting for the low air loss mattress (LAL - therapeutic mattress that uses blower and airflow to relieve pressure and keep the skin dry and prevent moisture build up). This deficient practice had the potential to result in the resident to be at risk of developing pressure ulcers. Findings: During a review of Resident 32's admission Record (AR) the AR indicated Resident 32 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis (no movement) of the arm, leg, and trunk on the same side of the body), dementia (a progressive state of decline in mental abilities), left knee and hand contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion). During a review of Resident 32's Minimum Data Set (MDS - a resident assessment and care screening tool) dated 11/20/2025, indicated, Resident 32 has severe impaired cognitive skills (ability to think and reason). The MDS indicated that Resident 32 was dependent on staff for eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene and turning and repositioning in bed. During a review of Resident 32's Initial History and Physical dated 2/11/2025, the initial History and Physical assessment indicated that Resident 32 does not have the capacity to understand and make decisions. During a review of Resident 32's Order Summary Report dated 1/5/2026, the summary report indicated a physician's order to apply a low air loss mattress for skin integrity. During a review of Resident 32's Braden Scale for Predicting Pressure Sore Risk dated 8/21/2025, indicated the resident was at high risk of developing pressure ulcer. During a review of Resident 32's Risk for Pressure Ulcers Care Plan dated 1/4/2024. Indicated Resident 32 was at risk for developing pressure ulcers and skin breakdown due to impaired mobility with intervention to apply pressure relieving/reducing device when in bed low air loss mattress. During an observation on 1/20/2026, at 9:51 AM in Resident 32's room was observed Resident 32 lying on a low air loss mattress with a setting for a person that weights 350 pounds (lb.) the maximum possible setting on the mattress. During an interview on 1/20/2026 at 10:25 AM with the Treatment Nurse (TX1) stated, Resident 32 weighs 140 pounds and the low air loss mattress setting was at set at the maximum setting of 350 lbs. stated that nursing did not monitor the bed setting every shift of the resident every shift. The TX 1 stated not be sure why the low air loss mattress was set at the maximum setting of 350 lbs. During an interview on 1/23/2026 at 1: 42 PM with the Director of Nurses (DON) stated that Resident 32's low air loss mattress setting should not have been left at maximum of 350 lbs. and should have been adjusted by nursing. DON stated the low air loss mattress constantly circulates air to keep the skin cool and dry to prevent moisture and the mattress should not have kept rigid. DON stated Resident 32 was at risk for pressure ulcers, falls or injury since the low air loss mattress maximum setting is to be used when transferring out of the bed.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 41's) with intravenous (IV- a catheter inserted with a needle into the vein) peripheral catheter (a thin tube inserted into a vein for therapeutic purposes such as administration of medications, fluids and/or blood products) on the left arm had dried up blood on the site covered with transparent dressing and was not changed in accordance to the facility's policy and procedure titled Peripheral Venous Catheter Insertion. This deficient practice can potentially cause infection on the on the IV site that can lead to severe infection. Findings: During a record review of Resident 41's admission Record (AR) dated 1/17/2026 indicated Resident 41 was admitted on [DATE], with the diagnoses of pneumonia (an infection/inflammation in the lungs), dysphagia (difficulty swallowing), History of malignant neoplasm of the prostate (cancerous tumor that can spread (metastasize) to other parts of the body). During a review of Resident 41's Progress Notes dated 1/18/2026 at 7:42 AM indicated that Resident 41 was to continue with intravenous medication (IV -fluids given directly into the blood stream), Ceftriaxone (Antibiotic Medication) for three days from the admission date of 1/17/2026. During a record review of Resident 41's Initial History & Physical dated 1/20/2026, indicated that Resident 41 has fluctuating capacity to understand and make decisions. During an observation on 1/20/2026 at 10 AM in Resident 41's room, Resident 41 was lying in bed with a peripheral catheter inserted to the left forearm between the elbow and the wrist area transparent clear dressing covered with dried up blood around the peripheral catheter site. A review of the Physician's order, dated 1/17/2026 timed at 4:47 PM, indicated Resident 41 was to receive Ceftriaxone1 gram (medication used to treat infection) intravenously (into the vein) on 1/18/2026, 1/19/2026, and 1/20/2026. During an interview on 1/20/2026 at 10:42 AM with Registered Nurse (RN3) stated, that Resident 41 had the peripheral catheter upon admission. RN3 stated to have noticed the red dry fluid around the peripheral catheter site but due to the risk of dislodgement and believing Resident 41 was a difficult stick (difficult to insert a peripheral catheter into the vein) RN3 felt comfortable leaving the dressing on until discontinuation of the intravenous catheter. During an interview on 1/23/2026 at 1:42 PM with the Director of Nurses (DON) stated, that nursing should have change the peripheral catheter dressing to prevent infection and to be able to assess new findings such as redness. During a review of the facility's policy and procedure titled, Peripheral Venous Catheter Insertion dated 3/2023, indicated that peripheral intravenous catheter sites will be changed when clinically indicated.		

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NAME OF PROVIDER OR SUPPLIER Ararat Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1230 E. Windsor Rd. Glendale, CA 91205	
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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident evaluations including a written report of a physical examination was completed within 72 hours following admission and the initial comprehensive visit was not done by the Nurse Practitioner, Physician Assistant, and the Clinical Nurse Specialist for one of six sampled residents (Resident 17). This deficient practice had the potential to result in an undetected decline in medical, health or psychosocial condition and can lead to a delay in necessary care, treatment, and services. Findings: During a review of Resident 17's admission Record (AR) indicated Resident 17 was admitted on [DATE] and readmitted on [DATE] with admitting diagnoses of acute embolism and thrombosis of left femoral vein (sudden blood clots that block blood flow), pneumonia (an infection/inflammation in the lungs). During a review of Resident 17's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/28/2025, the MDS indicated Resident 17 had a cognition (ability to think and reason) was intact. The MDS indicated that Resident 17 was partial/moderately dependent on staff for personal hygiene, putting on and taking off footwear, lower body dressing, upper body dressing, toileting hygiene, and supervision or touching assistance with oral hygiene, and eating. During a review of Resident 17's History and Physical assessment report, dated 1/19/2026 after being readmitted from the hospital on 1/16/2026 was performed, documented and signed on 1/20/2026 by the Physician Assistant PA). During an interview on 1/22/2026 at 10:25 AM with Director of Nurses (DON), stated, the PA came in today (1/22/2026) and not the primary physician to assess the resident (Resident 17). The DON stated the initial comprehensive assessment needs to be performed, documented, completed and signed by the attending physician. During a review of the facility's policy and procedure (P&P) titled, Physician Services & Visits, dated 10/24/2022, indicated, resident evaluations including a written report of a physical examination within 5 days prior to admission or within 72 hours following admission. The P&P indicated that the initial comprehensive visit cannot be done by the Nurse Practitioner, Physician Assistant, and the Clinical Nurse Specialist.		

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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. Based on observation, interview and record review, the facility failed to remove a lidocaine patch (a medicated sticky patch placed on the skin to numb an area and relieve pain) at 9 PM and place a new patch at 9 AM to ensure the patch was on for 12 hours and off for 12 hours as ordered by the physician order for one of two sampled residents (Resident 10) reviewed for pharmacy services. This failure resulted in Resident 10 receiving lidocaine in excess duration as prescribed which had the potential to cause adverse effects (undesired effect) of medication that include increased systemic absorption (process by which medication moves from its site of administration into the bloodstream, allowing it to travel throughout the entire body), skin irritation, or medication toxicity (the medicine becomes harmful because there is too much of it in the body), that could lead to a decline in Resident 10's condition, harm or hospitalization. Findings: During a review of Resident 10's admission Record (AR), the AR indicated the facility admitted Resident 10 on 12/4/2025 with diagnoses that included but not limited to spinal stenosis (the spaces in the spine have narrowed, which puts pressure on the spinal cord or nerves), lumbar (refers to the lower part of the back) region with neurogenic claudication (means leg pain, weakness or numbness caused by pressure on the nerves), fracture of second to fifth lumbar vertebrae (small bones that stack on top of each other to make up the spine), low back pain, and chronic kidney disease (CKD- damage to the kidneys so they cannot filter blood the way they should). During a review of Resident 10's untitled Care Plan (CP), initiated on 12/05/2025, the CP indicated Resident 10 was at risk for pain due to spinal stenosis, lumbar fracture and low back pain. The CP goals indicated Resident 10 would not have an interruption in normal activities due to pain and Resident 10 would verbalize adequate relief of pain. The CP intervention indicated for licensed nursing staff to administer lidocaine patch every 12 hours as ordered. During a review of Resident 10's Minimum Data Set (MDS- a resident assessment tool) dated 12/8/2025, the MDS indicated Resident 10 had intact cognition (ability to think, reason, and function). The MDS indicated Resident 10 required moderate assistance with toileting, showering and personal hygiene. During a review of Resident 10's physician's order dated 12/12/2025, the order indicated Resident 10 had an order for a lidocaine external patch four percent, apply to left lower back topically (applying a medicine, cream, or treatment directly onto a specific, localized part of the body) one time a day for pain management. Apply one (1) patch at 9 AM and remove at 9 PM, per schedule. During a concurrent observation and interview on 1/21/2025 at 8:52 AM with LVN 1 inside Resident 10's room, LVN 1 removed the lidocaine patch from Resident 10's left lower back and then placed a new patch on the same area. LVN 1 stated the patch should have been removed last night at 9 PM and a new patch to be placed at 9 AM as scheduled. LVN 1 stated the physician's order was to put the patch on for 12 hours and off for 12 hours. LVN 1 stated the doctor's order should be followed because the patch can cause skin irritations after prolonged use. During an interview on 1/23/2026 at 10:46 with the Director of Nursing (DON), the DON stated the lidocaine patch should be placed by the licensed nurse at 9 AM and removed at 9 PM. The DON stated the lidocaine patch should be removed after 12 hours to prevent absorption of the drug that the resident does not need. The DON stated excessive absorption of lidocaine in the body can be harmful to the residents. During a review of the facility's policy and procedure (P&P) titled, Medication administration, dated 7/2016, the P&P indicated, Medication will be administered by a licensed nurse per the order of an attending physician or licensed independent practitioner. During a review of the facility's P&P titled, Transdermal patches, dated 7/2016, the P&P indicated, At a minimum every shift, the licensed nurse will verify that the patch is present, intact and the skin around patch is free of skin irritation or other reactions.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 4), reviewed for use of unnecessary medications, was monitored for complications of Apixaban (a blood thinner medication) such as bruising and bleeding as indicated in the resident's care plan and the physician's order. This deficient practice had the potential for the resident not to receive immediate care or no care that can lead to a resident decline in well-being. for complication of Apixaban such as discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status, shortness of breath, nose bleeds. Findings: During a review of the admission Record (AR) indicated Resident 4 was admitted on [DATE] and readmitted on [DATE] with admitting diagnoses of atrial fibrillation (heart dysrhythmia), dementia (a progressive state of decline in mental abilities). During a review of the Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/31/2025, indicated Resident 4 cognitive (ability to think and reason) level was intact. During a review of Medication Administration Record (MAR), indicated that Resident 4 received Apixaban 5 milligrams (mg - a unit of measurement) twice a day from 1/1/2026 through 1/20/2026. During a review of the Order Summary Report dated 1/1/2026, indicated anticoagulant medication monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status, shortness of breath, nose bleeds every shift. During an observation on 1/20/2025 at 9:39 AM in Resident 4's room, Resident 4 was observed with purplish skin discoloration of irregular shape to left anterior hand. In an interview Resident 4 stated he does not know how he obtained the bruise and that might have accidentally bumped hand onto the furniture. During an interview with the Treatment Nurse (TXN 1) on 1/21/2025 at 3:45 PM stated that on 1/20/2026 she did not receive a report regarding bruising and skin abnormalities from the certified nurse assistants (CNA's). TX Nurse1 stated that the attending CNA should have reported the bruise for continuous monitoring and investigation. During an interview on 1/23/2026 at 2:20 PM with the Director of Nursing (DON), stated, that the CNA's who provide daily care should have reported to the license nurse the bruise that was on Resident 4's left hand. DON stated monitoring of anticoagulant side effects helps prevent serious complications such as uncontrollable bleeding. During a review of Resident 4's care plan titled Anticoagulant Therapy dated 1/30/2025, indicated that Resident 4's skin will be inspected daily and will report any abnormalities to the nurse. The care plan also indicated that all adverse reactions will be monitored, documented and reported. During a review of the facility's policy and procedure titled, Pressure Ulcer Prevention dated 2/1/2015, indicated that CNAs are required to inspect the resident's skin during ADL care and will report unusual findings to the License Nurse.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the documentation in the Licensed Nursing Weekly Summary (LNWS) accurately documented one of six sampled residents (Resident 5) reviewed for identifiable residents records, the actual status of having unplanned weight loss and behavior of yelling requiring the use of psychotropic medications (a medication that affects mood and behavior) in the weekly assessment from 12/1/2025, 12/8/2025, 12/22/2025, 1/12/2026, and 1/19/2026. This deficient practice can result in a lack of or a delay in communication between the staff and can interrupt provision of care/intervention to the resident. Findings: During a review of Resident 5's admission Record (AR), indicated Resident 5 was admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses of dementia (a progressive state of decline in mental abilities) with agitation, chronic kidney disease stage 4 (severe kidney function loss). During a review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/10/2025, the MDS indicated Resident 5 had severely impaired cognitive skills (ability to reason) and never/rarely made decisions. that was dependent on staff for eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking footwear, and personal hygiene. The MDS dated [DATE], indicated Resident 5 receives hospice services. During a review of Resident 5's Nutritional Risk Care Plan Report, dated 5/30/2024, indicated hospice care and services was discontinued on 12/2/2025. During a review of Resident 5's Order Summary Report (Physician Orders), dated 12/12/2025 indicated, Resident 5 was placed on weekly weight x 4 weeks for poor oral intake and weight loss. On 12/22/2025, a physician order indicated Resident 5 was started on Depakote (medication use to treat and manage symptoms for psychiatric disorders) 125 milligrams (mg - Metric unit of measurement, used for medication dosage and/or amount) twice a day for mood disorder for constant yelling. During a review of Resident 5's Licensed Nursing Weekly Summary (LNWS) dated 12/1/2025, 12/8/2025, 12/22/2025, 1/12/2026, and 1/19/2026, the LNWS indicated Resident 5 had no weight loss issues, and no antipsychotic medications administered for mood manifestation and its side effects, and no documentation of the weekly episodes of mood or behavioral changes. During a review of Resident 5's Unplanned/Unexpected weight loss Care Plan Report dated 12/11/2025, indicated monitor and evaluate any weight loss. During a review of Resident 5's Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 1/1/2026 - 1/23/2026, indicated Resident 5 received Depakote twice a day from 1/1/2026 - 1/23/2026 and had a total of 8 episodes of yelling in the day shift (7 - 3:30 PM), 25 episodes in the evening shift (3 - 11:30 PM) , and 11 episodes in the night shift (11 - 7:30 AM). During an interview on 1/22/2026 at 2:21 PM with Director of Nurses (DON) stated that the weight loss and the medication administered Depakote with the episodes of yelling which were being monitored should have been reflected in the LNWS the The documentation in the LNSW about Resident 5's behavior of yelling requiring administration of psychotropic medication and current un planned weight loss did not reflect the actual status of the resident. DON stated that not reflecting accurate residents' information in the documentation it is an opportunity to missed important information as well as communication to the physician and other interdisciplinary members. During a review of the facility's policy and procedure (P&P) titled, Licensed Nurse Weekly Progress Notes, dated 1/1/2016, indicated, the Licensed Nurse will document the resident's response and progress toward the goal and will identify possible skin, weight, medication, hydration and behavioral risk factors.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on interview and record review, the facility failed to post an accurate nurse staffing information worked by License Vocational Nurse (LVN) and Certified Nurse Aides (CNA) in accordance with the facility's policy and procedure titled Nursing Department - Staffing, Scheduling & Posting, when posted document on 1/20/2026 at 11:34 AM titled Posted Nurse Staffing Information indicated 11 to 7 shift actual staff are one LVN and two CNA's during morning facility rounds. (actual staff for 11 to 7 shift was posted in advance, during the day not at the beginning of the 11 to 7 shift). This deficient practice of posting inaccurate nurse staffing information in advance mislead information provided to the residents, resident's responsible parties and visitors about the nursing staffing for the residents. Findings: During a concurrent interview and record review of Posted Nurse Staffing Information on 1/20/2026 at 11:34 AM with Registered Nurse (RN) 1 at the nurses' station, the posting indicated there were one LVN and two CNAs assigned to work during the 11PM to 7AM shift. RN 1 stated, she works as a Director of Staff Development (DSD), and she was responsible as well as charge nurses in posting actual nursing staff per shift. RN 1 stated actual nursing staff for 11 to 7 shifts should have been blank until the beginning of 11 to 7 shift as per policy and should not be filled out in advance to ensure accurate nursing staff working that shift. RN 1 stated, the nursing posting was an error and a misleading information for to the residents, resident's responsible parties and visitors about the nursing staffing for the residents. During an interview on 1/21/2026 at 3:30 PM, the DON stated, the daily nursing postings are intended to inform the residents, resident's responsible parties and the visitors about the type and hours of nursing care provided in the facility. DON stated, it is not acceptable to write ahead of time the actual nursing staff per shift, it needs to be done at the beginning of each shift as per policy. DON stated these nursing posting must be accurate to prevent misinformation and confusion. A review of the facility's policy and procedure (P&P) titled, Nursing Department - Staffing, Scheduling & Posting. revised 10/24/2022, indicated: a) the facility will post the total number and the actual hours worked by licensed nursing and unlicensed nursing staff directly responsible for resident care per shift (RNs, LVNs, and CNAs), and b) the facility will post the nursing staffing data on a daily basis at the beginning of the each shift.		