STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555126	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ararat Convalescent Hospital	2373 Colorado Blvd. Los Angeles, CA 90041

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Certified Nursing Assistant (CNA) 1 immediately notify a licensed nurse and not move a resident after a fall on 8/19/2025 prior to a licensed nurse' assessment, in accordance with the facility's policy and procedure (P&P) titled, Response to Falls, for one out of three sampled residents (Resident 1) reviewed for falls. CNA 1 lifted Resident 1 from the floor and moved the resident back to bed. CNA 1 did not notify Licensed Vocational Nurse (LVN) 1 until after 20 minutes. These deficient practices had the potential for Resident 1 to suffer further discomfort and complications from the unwitnessed fall. On 8/19/2025, LVN 1 found Resident 1 shivering and shaking in pain after the fall with a swollen and discolored left foot. The result of an X-ray (imaging technology that creates images of people's body, including the bones, and is often used in diagnosis fractures), dated 8/19/2025, indicated that the resident had a left foot fracture. During a review of Resident 1's admission Record indicated the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), muscle weakness, dementia (a progressive state of decline in mental abilities), and osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 1's care plans indicated that Resident 1 is at risk for pain, muscle weakness or fractures [due to] Vitamin D deficiency, initiated on 8/27/2022, and revised on 9/26/2023. Interventions in the care plan included for gentle handling during care to avoid accidental fractures and minimize bone pain. During a review of Resident 1's care plan initiated on 8/27/2022, revised on 9/26/2023 indicated that Resident 1 is at risk for falls and had balance problem while walking. The care plan included interventions to have a floor mat on the side of Resident 1's bed, initiated on 3/19/2 025. During a review of Resident 1's History and Physical (H&P), dated 11/29/2024, indicated that the resident does not have the capacity to understand and make decisions. The H&P indicated that the resident has a history of hip fracture. During a review of Resident 1's Morse Fall assessment (an assessment to determine a resident's fall risk factors), dated 5/20/2025, the Fall assessment indicated that Resident 1 was assessed as a high risk for falls. The Fall Note indicated that Resident 1 had a history of falls. The Falls assessment also indicated that Resident 1 overestimates or forgets limits of her ability to walk safely. The Falls assessment did not indicate additional interventions to be added or revised to the resident's care plan as a result of this Fall assessment. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 8/19/2025, indicated the resident has severely impaired cognition (the ability to process thoughts). The MDS indicated that Resident 1 has impaired range of motion on one side of her body. The MDS indicated that Resident 1 required maximal assistance (helper does more than half the effort) on activities such as moving in bed from left to right, changing positions from sitting to lying, sitting to standing, and transferring to and from a bed to a chair. The MDS also indicated that Resident 1 is dependent (helper does all the effort) on activities such as toileting, lower body dressing, transferring to a toilet, and transferring to a tub or shower. The MDS also indicated that Resident 1 was not able to walk 10 feet at the time of assessment. During a review of Resident 1's care plans indicated that Resident 1 is at risk for pathological fractures [due to] aging process and osteoporosis, initiated on 3/4/2023, revised on 9/26/2023. Interventions included for gentle handling of resident to prevent injury/fractures, initiated on 3/4/2023. During a review of Resident 1's care plans indicated the resident is at risk for spontaneous fractures, initiated on 7/21/2023. The care plan indicated a goal to decrease potential of fall and resulting to fractures. The care plan also included interventions initiated on 7/21/2023 to handle resident gently while assisting with [Activities of Daily Living] and transfers. The care plan also indicated interventions for staff to handle gently when moving resident. During a review of Resident 1's Change in Condition (CIC), dated 8/19/2025, timed at 9:11 PM, authored by LVN 1, the CIC indicated that Resident 1 sustained a fall on 8/19/2025. The CIC indicated that the CNA (CNA 1) reported noticing discoloration on the resident's foot. The CIC indicated when LVN 1 assessed Resident 1, she found Resident 1 on the bed and that the top of Resident 1's left foot was swollen [with] bluish discoloration. The CIC indicated that LVN 1 asked the CNA whether he had noticed the discoloration earlier in the shift. The CNA responded that he saw the discoloration 20 minutes earlier, just before informing LVN 1. The CIC further indicated that the CNA found the resident on the floor mat and picked [the resident] up and put [the resident] back in bed. The CIC indicated that Resident 1 had a moderate to severe level of pain. The CIC further indicated that the physician was notified on 8/19/2025 at