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	03/12/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify, assess, and investigate a potential fall for Resident 1 after the resident reported pain and stated she had fallen on 3/2/2026.Nursing staff did not initiate the facility's fall policy, including completing a postˆfall assessment, neurological monitoring, incident reporting, reassessment of mobility status. This failure resulted in delayed identification of injuries and placed the resident at risk for further harm, unmanaged pain, and unmet care needs.Findings: During a review of Resident 1's admission Record, the resident was noted to have been admitted on [DATE] and readmitted on [DATE], with diagnoses including multiple rightˆsided rib fractures, pneumonia, and dementia. During a review of Resident 1's History and Physical dated 12/31/2025, the documentation indicated the resident had fluctuating capacity to understand information and make decisions. During a review of the Minimum Data Set (MDS) dated [DATE], the assessment indicated the resident had moderate cognitive impairment, used a wheelchair and walker for ambulation, and required supervision and moderate assistance with activities of daily living including eating, toileting, and dressing. During a review of the Morse Fall Risk assessment dated [DATE], the resident was identified as high risk for falls with a score of 80, with documentation of a history of falls and a tendency to overestimate functional abilities. During a review of the facility's investigation summary dated 3/5/2026, the resident was documented as having reported to multiple staff, including a CNA and therapy staff, that she had experienced a fall. Later that evening, at approximately 11:00 PM, the resident reported pain while being assisted to the bathroom using a frontˆwheel walker. During a review of a CT scan dated 3/3/2026, the results indicated probable acute, nondisplaced fractures of the right 5th and 10th ribs. During a review of progress notes titled IDT Notes dated 3/6/2026, an interdisciplinary team meeting was documented with the social services director, a registered nurse, and a family member present. CT scan results from the acute hospital reflected probable acute nondisplaced right rib fractures. The family member reported that the hospital physician stated it would be unlikely for the resident to sustain multiple rib fractures without a traumatic fall. During a review of progress notes titled Health Status Note dated 3/3/2026, the resident stated she had fallen when asked about her pain. During an interview on 3/12/2026 at 10:20 AM, the Director of Nursing (DON) stated that during the initial assessment, RN 1 reported the resident complained of pain and stated she had fallen that morning. The DON stated no fall incident report was completed because the fall was unwitnessed and the CNA had not observed it. During an interview on 3/12/2026 at 10:30 AM, RN 1 stated that on the morning of 3/2/2026, CNA 2 reported the resident pointed to her right lower back and hip area indicating pain during morning care. RN 1 stated she and the LVN supervisor assessed the resident, who again indicated pain by pointing to her hip. RN 1 stated the resident told the LVN supervisor she had fallen; however, RN 1 stated she did not believe a fall occurred because no bruising was visible. RN 1 confirmed the resident was high fall risk and typically waited at the bedside for assistance. During an interview on 3/12/2026 at 1:37 PM, the DON stated the resident was already on fall precautions due to her high fallˆrisk status. The DON reported the facility did not implement the fall policy because staff believed no fall had occurred (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	based on the absence of visible bruising. The DON acknowledged the facility should have conducted a thorough assessment and investigated the potential fall. As a result, required interventions-including 72ˆhour neurological checks, reassessment of mobility status, and an interdisciplinary review-were not completed. The DON acknowledged this failure could have resulted in delayed identification and treatment of injuries and pain. During a review of the facility's policy titled Fall Risk Assessment, revised March 1, 2015, the policy indicated the facility will ensure the resident's environment is free of accident hazards and that residents receive adequate supervision to prevent accidents. The policy stated a fall may be witnessed or reported by the resident or any observer. During a review of the facility's policy titled Fall Management Program, revised February 29, 2024, the policy indicated the fall program aims to prevent falls through assessment, interventions, education, and ongoing evaluation. The policy required postˆfall assessments and investigations within 24 hours, review and revision of the care plan as needed, and an interdisciplinary falls committee meeting within 72 hours to complete a rootˆcause analysis. During a review of the facility's policy titled Response to Falls, dated March 31, 2025, the policy indicated staff must respond promptly and appropriately to resident falls. Required postˆfall actions included assessment, investigation, neurological flow sheet completion for unwitnessed falls, documentation of notifications, and completion of an incident report. The interdisciplinary falls committee was required to review each fall and modify the plan of care as indicated.