STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555579	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ararat Nursing Facility	15099 Mission Hills Road Mission Hills, CA 91345

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

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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	Based on interview and record review, the facility failed to ensure interventions to prevent falls were in place for one of three sampled residents (Resident 3) when Resident 3 had a fall on 11/19/2025 by failing to: 1. Ensure the Situational Background Assessment Recommendation (SBAR - a structured communication tool used primarily in healthcare for concise, clear updates, especially during handoffs or critical situations, ensuring all team members understand the resident's status and needs) Communication Form, dated 11/19/2025, was complete and accurate for Resident 3's Fall. 2. Ensure the Incident Note (IN - a formal, factual document that records any unplanned or unusual event that affects a resident, visitor, or staff member's safety or well-being) for Resident 3's fall on 11/19/2025 was complete and accurate. 3. Ensure Resident 3's Interdisciplinary Care Conference (IDT - a formal meeting where a team of healthcare professionals, along with the resident and their family, come together to discuss, plan, and coordinate the resident's overall care and treatment goals) was accurate to Resident 3's fall on 11/19/2025. These deficient practices had the potential to place Resident 3 at risk for more falls in the facility.Findings: During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 2/7/2020 and readmitted the resident on 10/29/2025 with diagnoses including age-related osteoporosis (a bone disease that makes bones weak and brittle, like a honeycomb with too many holes, increasing the risk of fractures from even minor falls), glaucoma (a group of eye diseases that damage the optic nerve, often due to increased pressure inside the eye from fluid buildup, leading to gradual, permanent vision loss, usually starting with peripheral [side] vision and potentially causing blindness if untreated), and muscle weakness (generalized). During a review of Resident 3's Fall Risk Evaluation (a process used by healthcare providers to determine a person's likelihood of falling), dated 10/29/2025, the Fall Risk Evaluation indicated Resident 3's fall risk score was 24 (a total score of 10 or greater, the resident should be considered at high risk for potential falls). During a review of Resident 3's Care plan for risk for fall secondary to fall assessment score above 10 representing a high risk, initiated on 10/31/2025, the Care plan indicated interventions that included to keep Resident 3's bed in lowest degree of elevation while in bed, place floor mat next to Resident 3's bed to prevent the resident from injuries and keep environment free of hazards such as wet spots and keep pathways free of clutter. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 11/5/2025, the MDS indicated Resident 1 sometimes understood and was sometimes understood. The MDS indicated Resident 1 was dependent (helper does all the effort) on facility staff for oral hygiene, showering, lower body dressing, putting on and taking off footwear and personal hygiene and required substantial assistance (helper does more than half the effort) from facility staff for toileting and upper body dressing. During a review of Resident 3's SBAR Communication Form, dated 11/19/2025, the SBAR Communication Form indicated Resident 3 had a fall. The SBAR Communication Form Appearance section indicated Resident 3 was awake, verbally responsive, able to make needs known and able to follow commands. The SBAR Communication Form indicated Resident 3 had no change in level of consciousness noted, was able to move all extremities with no pain within previous limitations, offered fluids, and toilet needs met promptly. The SBAR Communication Form Review and Notify section indicated the physician (MD) was notified on 11/19/2025 at 11:15p.m. The SBAR Communication Form indicated the recommendation by the MD was left blank. During a review of Resident 3's Care plan for un-witnessed fall/at risk for injuries, initiated on 11/20/2025, the Care plan indicated interventions included falling star program (initiative used to identify and protect residents at high risk for falls), bilateral floor mats (specialized mats used to cushion falls for at-risk residents who get up unexpectedly to reduce serious injury) next to bed, and continue with rehab evaluation and treatment. During a review of Resident 3's IN, dated 11/20/2025, the IN indicated Resident 3 had an unwitnessed fall on 11/19/2025 at 11:07 p.m. The IN indicated Resident 3 was awake, alert and verbally responsive, able to make needs known and follow commands, able to move all extremities within previous limitation, and with no reported pain or discomfort. The IN indicated Resident 3 had no skin issues or impairment, nor discoloration noticed, all needs met toilet needs assisted promptly, neurological check (assessments of the brain, spinal cord, and nerves to evaluate the nervous system's function, checking mental status, motor skills, balance, reflexes, and senses) started, and will be placed on 72-hour post fall monitoring. The IN indicated to not proceed with Restorative Nurse Assistant (RNA) morning exercise. The MD and family were made aware with no order for transfer to hospital at this time, bed in low position, call light within reach and encouraged to use it for assistance. During a review of Resident 3's