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	02/18/2026

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 - Some	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 ensure one of four sampled residents (Resident 1), who had a history of multiple falls in the facility (12/20/2024 and 9/30/2025) and required partial/moderate assistance (helper does less than half the effort) from facility staff with bed mobility (the ability to roll from lying on back to left and right side, and return to lying on back on the bed), remained free from accidents by failing to:1. Initiate the facility's Falling Star Program (a resident safety initiative that uses a visual symbol, like a falling star, to identify residents at high risk for falls in healthcare settings) on 6/24/2025 when Resident 1 was identified as being at higher risk for falls following a fall incident on 12/20/2024. A fall risk assessment was completed for Resident 1 on 12/20/2024, however Resident 1 was not added to the facility's Falling Star Program until 11/1/2025 (nearly one year later).2. Ensure Certified Nurse Assistant (CNA) 1 requested additional support from another facility staff when providing morning care (changing bed linens and resident's incontinence briefs (disposable, underwear designed for managing bladder or bowel incontinence [having no or insufficient voluntary control over urination or defecation]) to Resident 1 on 11/1/2025. These deficient practices resulted to Resident 1's fall on 11/1/2025 at 6:15 a.m., during morning care, when CNA 1 rolled Resident 1 to her (Resident 1) left side of the bed and Resident 1, unable to hold self (Resident 1) on the side of her bed, fell to the floor. Resident 1 sustained a laceration (a deep cut or tear in the skin) on the left eyebrow, skin tear (wounds caused by friction or shear that separates skin layers) on the left forehead, skin tear on the left wrist, and bleeding. Registered Nurse (RN) 4 cleaned the laceration site with normal saline (a sterile solution used to clean and treat wounds) and applied a dressing (a pad or cover applied to an injury or wound to protect it, promote healing and prevent infection) to control the bleeding. Resident 1 complained of headache with level of three (mild pain) out of 10 on the numeric pain rating scale (a pain assessment tool that uses a scale ranging from zero [0 - no pain] to 10 [worst pain imaginable], to quantify pain intensity). RN 4 administered Tylenol (a brand of medication used to treat mild to moderate aches and pains) 325 milligrams (mg - unit of measurement) two (2) tablets to Resident 1 on 11/1/2025 at 6:15 a.m. On 11/1/2026 at 7:19 a.m., the facility transferred Resident 1 to the General Acute Care Hospital (GACH) for further evaluation due to head injury where Resident 1 received seven (7) sutures (sterile medical devices (threads and needles) used to hold body tissues together after injury) on the left eyebrow laceration. 3. Ensure Resident 1's bilateral floor mats (high-impact, shock-absorbing pads placed beside beds to minimize injury from falls, fractures, and head trauma) were placed next to Resident 1's bed.4. Ensure facility staff completed Resident 1's Fall Risk Assessment after Resident 1 had an episode of fall on 11/1/2025. 5. Ensure Resident 1's Care Plan was revised after Resident 1's fall incident on 12/20/2025. These deficient practices had the potential to increase the chances of Resident 1 incurring accidents such as falls with injury.Findings:During a review of (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 - Some	Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 6/27/2019 and readmitted on [DATE] with diagnoses including chronic diastolic (congestive) heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), right shoulder rotator cuff tear or rupture (damage to the muscles/tendons, causing pain, weakness, and limited motion), wedge compression fracture (a type of spinal injury where the front part of a vertebra [the individual bones of the spine] collapses while the back remains intact, causing the bone to take on a wedge shape) of T11-T12 vertebra sequela (the long-term or lasting effects resulting from a previous injury to the eleventh [11th] and twelfth [12th] thoracic vertebrae), and muscle weakness. During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 7/1/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Fall Risk Assessment form, dated 12/20/2024, the Fall Risk Assessment form indicated Resident 1 had a fall risk score of 28 (a total score above 10 represents a high risk for falls). During a review of Resident 1's Interdisciplinary (or Interdisciplinary Team [IDT] - is a collaborative, team-based approach where professionals from different specialties work together to create and implement a single, unified, and comprehensive care plan for a resident) Care Conference Review form, dated 12/20/2024, the IDT Care Conference Review form indicated that on 12/20/2024 Resident 1 had an episode of fall. The IDT Care Conference Review form indicated that while ambulating (walking) to the restroom, Resident 1 slipped and was assisted to the floor by a facility staff (name not indicated).During a review of Resident 1's Care Plan for functional abilities of everyday activities, initiated on 5/19/2025, the Care Plan indicated that Resident 1 required assistance with bed mobility (movement). The Care Plan interventions indicated that as needed, two or more facility staff will assist Resident 1 with bed mobility. During a review of Resident 1's Fall Risk Assessment form, dated 10/22/2025, the Fall Risk Assessment form indicated Resident 1 had a fall risk score of 20. The Fall Risk Assessment form indicated Resident 1 had one or two falls in the past 90 days. During a review of Resident 1's Incident Report (an objective, written account of an unexpected event such as falls or injuries affecting residents) for a witnessed fall, dated 11/1/2025, the Incident Report indicated on 11/1/2025, at 6:15 a.m., RN 4 received a report from Licensed Vocational Nurse (LVN) 1 that Resident 1 was observed on the floor next to her (Resident 1) bed during the morning care. The Incident Report indicated that while CNA 1 turned Resident 1 to her (Resident 1) side on the bed to place a bed protector (waterproof, and absorbent barrier placed over sheets to protect the mattress from incontinence, fluids, and damage), Resident 1 was unable to hold herself (Resident 1) and fell. The Incident Report indicated there was no floor mat (high-impact, shock-absorbing pads placed beside beds to minimize injury from falls, fractures, and head trauma) present on the floor. The Incident Report indicated RN 4 observed a laceration on the left side of the left eyebrow with bleeding, skin tear on the left side of the forehead, and skin tear on the left wrist. The Incident report indicated Resident 1 complained of pain level of three out of 10 on the numeric pain rating. The Incident Report indicated an ice pack was applied to Resident 1's forehead and Resident 1 received Tylenol 325 mg 2 tablets. During a review of Resident 1's Progress Note, dated 11/1/2025, timed at 2 p.m., the Progress Note indicated Resident 1 returned to the facility from GACH at 12 p.m. (on 11/1/2025). The Progress Note indicated Resident 1 had seven sutures and skin tear on the left forearm (skin tear measurement not indicated). During a review of Resident 1's Progress Note, dated 11/1/2025, timed at 2:28 p.m., the Progress Note indicated that on 11/1/2025, at 12 p.m., Resident 1 returned to facility from GACH. The Progress Note indicated Resident 1's laceration site measured six (6) centimeters (cm - unit of measurement) in (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	length, 1.5 cm in width, and 0.1 cm in depth. During a review of Resident 1's Physician Orders, the Physician Orders indicated the following:- 11/1/2025: Transfer Resident 1 via 911 (phone number used to contact the emergency services) for further evaluation related to fall. - 11/1/2025: Amoxicillin (a medication used to treat infections caused by bacteria such as skin infection) Capsule 500 milligram (mg-unit of measurement). Give one capsule by mouth every eight hours prophylactically (to prevent infection) for sutures. During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 11/2025, the MAR indicated Resident 1 received Tylenol 325 mg two tablets at 6:15 a.m. for a pain level of five (5 - moderate) out of 10 on the numeric pain rating scale (the Incident Report dated 11/1/2025 indicated pain level of 3, while MAR indicated pain level of 5).During a review of Resident 1's Interdisciplinary Care Conference Record, dated 11/3/2025, the IDT Care Conference Record indicated that Resident 1 had stated she (Resident 1) was feeling weak and was not able to hold herself (Resident 1) trying to turn and fell from the bed. The IDT Care Conference Record indicated that Resident 1 stated that she (Resident 1) was not comfortable for CNA 1 to care for her (Resident 1) again. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 10/27/2025, the MDS indicated Resident 1 had intact cognitive functioning (resident's mental abilities, impacting their ability to think, learn, remember, reason, and make decisions). The MDS indicated Resident 1 was dependent (helper does all of the effort) on facility staff for toileting hygiene, showers, and lower body dressing. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) from facility staff for moving from sitting on the side of the bed to lying flat on the bed, moving from lying on the back to sitting on the side of the bed, upper body dressing, and personal hygiene. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) from facility staff for rolling from lying on back to left and right side on the bed. The MDS indicated Resident 1 was frequently incontinent (having no or insufficient voluntary control) of bowel and bladder. During a review of CNA 1's Performance Correction Notice, dated 2/17/2026, the Performance Correction Notice indicated that CNA 1 was receiving a final written warning related to Resident 1's fall on 11/1/2025 and was suspended until further notice. The Performance Correction Notice indicated that CNA 1 must follow safety, health, and security rules and procedures when providing care to residents. The Performance Correction Notice indicated that CNA 1 should have gotten additional help or have requested assistance from a Charge Nurse (LVN) while providing care to Resident 1. During an interview on 2/12/2026 at 4:10 p.m. with Resident 1, Resident 1 stated that few months ago (could not recall exact date) while CNA 1 was changing bed linens and turned Resident 1 to left side, Resident 1 lost hold of the bed and fell on the floor. Resident 1 stated her face touched the floor and she sustained a cut on the left side of the forehead. During a concurrent observation and interview on 2/12/2026 at 4:30 p.m. with RN 2 in Room A (Resident 1's room), there was no floor mat (high-impact, shock-absorbing pads placed beside beds to minimize injury from falls, fractures, and head trauma) observed next to Resident 1's bed. RN 2 stated it was the responsibility of the RN and charge nurse to ensure that Resident 1's Care Plan interventions were followed. RN 2 stated failure to provide bilateral floor mats to Resident 1 had the potential to increase Resident 1's risk of injury such as fractures if Resident 1 fell again.During a concurrent interview and record review on 2/12/2025 at 4:46 p.m. with RN 2, Resident 1's Care Plan for witnessed fall initiated on 11/3/2026, was reviewed. The Care Plan interventions indicated Resident 1 would have bilateral floor mats. RN 2 stated it was the responsibility of the RN and charge nurse to ensure that Resident 1's Care Plan interventions were followed. RN 2 stated failure to provide (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bilateral floor mats to Resident 1 had the potential to increase Resident 1's risk of injury such as fractures if Resident 1 fell again.During an interview on 2/13/2026 at 12:16 p.m. with RN 4, RN 4 stated that on 11/1/2026, at approximately 6:15 a.m. (per progress note), she (RN 4) received a call from LVN 1 regarding a fall incident at Station A (Resident 1's nursing station). RN 4 stated she immediately entered Resident 1's room and found Resident 1 lying supine (lying flat on the back with face and torso facing upward) on the floor next to Resident 1's bed. RN 4 stated that there was blood visible on Resident 1's forehead near the left eyebrow (cannot recall the exact location) and approximately one milliliter (ml - unit of measurement) blood was visible on the floor next to Resident 1's head. RN 4 stated she assessed Resident 1 and cleaned Resident 1's forehead wound with normal saline and gauze (bleached cotton cloth of plain weave used for bandages and dressing). RN 4 stated that CNA 1 had told her (RN 4) that during cleaning Resident 1 was weak and was not able to hold herself (Resident 1) in bed. RN 4 stated that facility staff should consider safety of residents before starting care and ask for assistance if needed. During an interview on 2/13/2026 at 1:05 p.m. with LVN 4, LVN 4 indicated there was no documented evidence that Resident 1 was added to the Falling Star Program prior to 11/1/2025.During a concurrent interview and record review on 2/17/2026 at 11:14 a.m. with LVN 2, Resident 1's Fall Risk Assessment forms, dated 7/25/2025 to 10/22/2025 were reviewed. LVN 2 stated the facility failed to complete a fall risk assessment after Resident 1 had an episode of fall on 11/1/2025. LVN 2 stated a fall risk assessment should be completed upon residents' admission, quarterly and after a fall incident. LVN 2 stated since Resident 1's fall risk was not assessed after a fall episode there was a potential for Resident 1's fall prevention intervention to be incomplete or inaccurate. LVN 2 stated failure to compete a fall risk assessment after Resident 1's fall episode on 11/1/2025 had the potential to increase Resident 1's risk of recurrent falls.During an interview on 12/17/2026 at 12:04 p.m. with RN 1, RN 1 stated a fall risk assessment should have been completed after Resident 1's fall episode on 11/1/2025. RN 1 stated based on the post fall risk assessment facility staff will identify appropriate interventions to prevent falls. RN 1 stated failure to assess Resident 1 had the potential to increase Resident 1's risk for falls.During an interview on 2/17/2026 at 12:29 p.m. with RN 1, RN 1 stated it was the responsibility of the licensed facility staff to update Resident 1's Care Plan after post fall IDT meeting on 12/20/2024. RN 1 stated Care Plan was a guide for the facility staff to provide care to residents. RN 1 stated failure to update Resident 1's Care Plan with fall prevention interventions had the potential to increase Resident 1's risk for fall.During a concurrent interview and record review on 2/17/2026 at 3:02 p.m. with LVN 3, Resident 1's Care Plan was reviewed. LVN 3 stated the information discussed during the IDT meeting after Resident 1's fall episode on 12/20/2024 should have been addressed in Resident 1's Care Plan. LVN 3 stated there was no documented evidence that Resident 1's Care Plan was updated after the fall incident on 12/20/2024. LVN 3 stated the failure to revise Resident 1's Care Plan post fall had the potential for Resident 1 not to receive appropriate fall prevention interventions possibly leading to a recurrent incident of fall.During an interview on 2/18/2026 at 11:22 a.m. with CNA 1, CNA 1 stated that she was the CNA assigned to Resident 1 on 11/1/2025 for 11 p.m. to 7 a.m. shift (work schedule). CNA 1 stated on 11/1/2025, at approximately 6 a.m., she (CNA 1) entered Resident 1's room to provide morning care prior to end of the shift. CNA 1 stated that when she (CNA 1) entered Resident 1's room Resident 1 was sleeping. CNA 1 stated she explained to Resident 1 that she (CNA 1) will change Resident 1's bed linens and incontinent briefs. CNA 1 stated she (CNA 1) could not recall asking Resident 1 if she (Resident 1) was able to move and hold herself (Resident 1) on the side of the bed prior to initiating care on 11/1/2025 at 6 a.m. CNA 1 stated that after cleaning Resident 1 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	while Resident 1 was supine, she (CNA 1) turned Resident 1 to her (Resident 1) left side to place the bed protector. CNA 1 stated she was holding Resident 1 with right hand from Resident 1's right arm while trying to place the bed protector with left hand. CNA 1 stated that approximately 10 to 15 minutes after initiation of care, while lying on her (Resident 1) left side at the edge of the bed, Resident 1 slipped from her (CNA 1) hand and fell on floor. CNA 1 stated she (CNA 1) immediately approached Resident 1 who was lying next to the bed, on the floor. CNA 1 stated she (CNA 1) immediately screamed for assistance and LVN 1 entered Resident 1's room. CNA 1 stated that Resident 1 had visible blood on the left side of her face near the forehead, approximately equal to the size of her (CNA 1) palm. CNA 1 stated that prior to the fall incident on 11/1/2025, CNA 1 had noticed that Resident 1 was less active and was having more difficulty moving in bed. CNA 1 stated that she should have asked for assistance from facility staff before providing care to Resident 1. CNA 1 stated Resident 1's fall on 11/1/2025 could have been prevented if another facility member was assisting her (CNA 1) during Resident 1's morning care on 11/1/2025. During an interview on 2/18/2026 at 11:54 a.m. with the Director of Nursing (DON), the DON stated that Resident 1's fall on 11/1/2025 could have been prevented if CNA 1 had asked for additional assistance from facility staff during Resident 1's as it was indicated in Resident 1's Care Plan. The DON stated that CNA 1 had received a performance correction notice and training related to poor care provided to Resident 1. During an interview on 2/18/2026 at 1:36 p.m. with LVN 1, LVN 1 stated that on 11/1/2025, at approximately 6 a.m. (cannot recall exact time), while in Station A (nursing station where Resident 1's room was located), she (LVN 1) heard CNA 1 call for assistance in Resident 1's room. LVN 1 stated that upon entering Resident 1's room, she (LVN 1) observed Resident 1 on the floor next to the bed, lying on her (Resident 1) back. LVN 1 stated Resident 1's bed was high at approximately half of her (LVN 1) height of 5 feet (ft - unit of measurement) and 4 inches (in-unit of measurement). LVN 1 stated there was visible blood on Resident 1's forehead. LVN 1 stated there was blood on the floor next to Resident 1's head approximately equal to a large drink and required 3 face towels to clean. LVN 1 stated that Resident 1 told her (LVN 1) that she (Resident 1) was not young and could not sustain herself (Resident 1) on the bed. During a concurrent interview and review on 2/18/2026 at 12:29 p.m., the facility-provided policy and procedure (P&P) titled, Falling Star Program, reviewed on 7/28/2025, was reviewed with RN 1. The P&P indicated, The Facility will ensure that staff is aware of resident who is at high risk for falls. I. The Facility's Interdisciplinary Team (IDT) will determine the need to place resident in ‘Falling Star' Program. II. The ‘Falling Star' program will be used as a post-fall intervention to prevent falls and injuries. RN 1 stated that Resident 1 should have been added to the facility's Falling Star Program after Resident 1 was identified as having high risk for fall and experiencing a fall episode in the facility. RN 1 stated the staff failed to follow facility's Falling Star Program P&P. RN 1 stated the failure to add Resident 1 to the Falling Star Program had the potential to increase Resident 1's risk of falls.During a review of the facility-provided P&P titled, Fall Management Program, last reviewed on 7/28/2025, the P&P indicated, it is the policy of this facility to provide the highest quality care in the safest environment for the residents residing in the facility. The Facility has developed a Fall Management Program that strives to prevent resident falls through meaningful assessments, interventions, education, and reevaluation. I. Assessment: A. The Licensed Nurse will assess each resident for their risk of falling upon admission, quarterly, with significant change in condition, and as needed. C. Based on the information gathered from the history and assessment of the resident, the Nursing staff, and Interdisciplinary Team (IDT), with input from the Attending Physician, will identify the implement interventions to reduce the risk of falls. II. Care Planning: A. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Nursing Staff will develop a plan of care specific to the residents' needs with interventions to reduce the risk of falls. B. The Interdisciplinary Team will routinely review the plan of care at a minimum of quarterly, with a significant change in condition, and post fall. Interventions will be implemented or changed based on the resident's condition and response. During a review of the facility-provided policy and procedure titled, Response to Falls, last reviewed on 1/26/2026, the P&P indicated, To ensure the Facility responds quickly and appropriately to resident falls in a manner that addresses both the resident's immediate needs and longer-term fall prevention. V. The Interdisciplinary Team (IDT) will review the investigation reports on a regular bases, as they may occur and make systemic changes to reasonably limit future occurrences, consider change in POC interventions, system changes, etc. Documentation: A. Licensed Nurse . vii. Revise resident's Care Plan as necessary.During a review of the facility-provided policy and procedure titled, Care Planning, last reviewed on 1/26/2026, the P&P indicated, To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. V. The IDT will revise the Comprehensive Care Plan as needed at the following intervals.B. As indicated by changes in the resident's condition; (care plans must be updated for any change in condition, regardless of physician's orders promptly).

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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 medical records for one of four sampled residents (Resident 1) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to ensure accurate documentation of Fall Risk Assessment (a tool to identify residents at high risk of falling by evaluating factors such as medical conditions, vision, balance, mobility, medications) form. This deficient practice had the potential for inaccurate medical interventions for Resident 1. Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 6/27/2019 and readmitted on [DATE] with diagnoses including chronic diastolic (congestive) heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), right shoulder rotator cuff tear or rupture (damage to the muscles/tendons, causing pain, weakness, and limited motion), wedge compression fracture of T11-T12 vertebra sequela (lasting effects of a collapsed, wedge-shaped thoracic vertebra), and muscle weakness. During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 7/1/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/21/2026, the MDS indicated Resident 1 had intact cognitive functioning (resident's mental abilities, impacting their ability to think, learn, remember, reason, and make decisions). The MDS indicated Resident 1 was dependent (helper does all of the effort) on facility staff for toileting hygiene, showers, and lower body dressing. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) from facility staff for rolling from lying on back to left and right side on the bed, moving from sitting on the side of the bed to lying flat on the bed, moving from lying on the back to sitting on the side of the bed, upper body dressing, and personal hygiene. During a concurrent interview and record review on 2/18/2026 at 12:29 p.m. with Registered Nurse (RN) 1, Resident 1's Fall Risk assessment dated [DATE], 10/1/2025, and 10/22/2025 were reviewed. The Fall Risk Assessments dated 7/29/2025, 10/1/2025, and 10/22/2025 indicated that section F (Assessment of resident's systolic blood pressure variation when changing positions between lying and standing) was not assessed. RN 1 stated Resident 1's Fall Risk Assessment for the months of July (2025) and October (2025) were incomplete. RN 1 stated the assessment did not describe Resident 1's condition correctly which could potentially lead to lower score level. RN 1 stated failure to complete the fall assessment correctly had the potential to affect Resident 1's care leading to higher risk for falls. During a review of the facility-provided policy and procedure titled, Documentation Nursing, last reviewed on 1/26/2026, the P&P indicated, Nursing documentation will be concise, clear, pertinent, and accurate. Alert Charting: A. Alert charting is documentation done to track a medical event for a period of 72 hours or B. Alert charting is completed by professional staff rather than non-professional staff. D. Alert charting describes what is going on. (a) Describe the resident's condition, include what you see, hear, smell, feel, etc . (c) Describe what you have done in response to what is going on with the resident.