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	05/29/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure professional standards of practice were followed for one of three sampled residents (Resident 3) when Certified Nurse Assistant (CNA) 1 found Resident 3 on her knees next to her roommate's bed on 5/15/2025. The facility failed to: 1. Complete Resident 3's Change of Condition (COC) assessment. 2. Monitor Resident 3 for 72 hours after the fall. 3. Conduct neuro checks on Resident 3. 4. Implement interventions to prevent Resident 3 from further falls. These failures had the potential to result in delayed care and services following Resident 3's fall. Findings: During a review of Resident 3's admission Record, the admission record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), repeated falls, and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 3's Minimum Data Set [MDS)] resident assessment tool), dated 4/9/2026, the MDS indicated Resident 3 had impaired cognitive skills (ability to think, understand, learn, and remember) for daily decision making and needed dependent assistance (helper does all of the efforts) for toileting hygiene, showers, lower body dressing and putting on/taking off footwear. During a review of Resident 3's History and Physical (H&P - a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 1/31/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During an interview on 5/29/2026 at 10:14 a.m. with Licensed Nurse (LVN) 1, LVN 1 stated that on 5/15/2025 around 9 p.m., CNA 1 called for assistance in Resident 3's room. LVN 1 stated that she went into Resident 3's room immediately and observed Resident 3 kneeling on the floor next to her roommate's bed. LVN 1 stated that they assisted Resident 3 into a seated position and called Registered Nurse (RN) 1 to assist Resident 3 back into bed. LVN 1 stated that she did not know how Resident 3 got out of bed because she had never seen Resident 3 ambulate. LVN 1 further stated that Resident 3 had a fall but did not investigate the fall because she focused on immediately separating Resident 3 from her roommate. During an interview on 5/29/2026 at 11:05 a.m. with CNA 1, CNA 1 stated that on 5/15/2026 at approximately 8:30 p.m., CNA 1 heard a voice coming from Resident 3's room. CNA 1 stated that she immediately entered Resident 3's room and saw Resident 3 kneeling beside her roommate's bed. CNA 1 stated that she called for help, and LVN 1 arrived in the room right away. CNA 1 stated that LVN 1 assisted Resident 3 to a sitting position on the floor mat. CNA 1 stated that LVN 1 and RN 1 assisted Resident 3 back to bed. CNA 1 stated that they did not know how Resident 3 ended up on the floor since CNA 1 had put Resident 3 in bed prior to finding Resident 3 on the floor. During an interview on 5/29/2026 at 2:13 p.m. with Risk Management (RM) nurse, the RM stated that after the facility completed the investigation regarding Resident 3's physical altercation the CNA 1 stated that Resident 3 was on her knees on the floor. RM stated that resident had an unwitnessed fall on 5/15/2026 and the facility did not complete a COC because the staff was focused on separating Resident 3 from her roommate. RM stated that Resident 3 was not monitored for the unwitnessed fall and staff should have completed a COC evaluation and monitored Resident 3 for 72 hours after the fall. During an interview on 5/29/2026 at 3:27 p.m. with Assistant Director of Nursing (ADON), the (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADON stated that Resident 3 was found on her knees by CNA 1 on 5/15/2026. The ADON stated that Resident 3 had an unwitnessed fall and that the facility's policy (P&P) titled, Fall Management Program was not followed when the licensed nurse did not complete an incident report and a post fall assessment within 24 hours. The ADON stated that Resident 3 did not receive high quality of care after the unwitnessed fall because there was no documentation indicating that Resident 3 was monitored for 72 hours after the fall, no neuro checks were done, and no interventions were implemented to prevent Resident 3 from falls. During a review of the facility's P&P titled, Fall Management Program dated 4/6/2026, the P&P indicated, Following a resident's fall, the licensed nurse will complete an incident report and a Post-Fall Assessment & Investigation within 24 hours or as soon as practicable. Nursing staff will document the resident's response to interventions being utilized in the resident's medical record.