STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055111	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain View Subacute and Nursing Center	5310 Fountain Ave Los Angeles, CA 90029

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on interview and record review the facility failed to ensure care plan interventions were followed for one of five sampled residents (Residents 3). This failure had the potential to negatively impact the delivery of care and services to Resident 3. Cross reference with F842 Findings: A review of Resident 3 ' s Admission Record dated 11/29/24, indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD - kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), hemiplegia (paralysis on one side of the body and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side, and diabetes mellitus type two (DMII -- a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 3 ' s Minimum Data Set (MDS, a resident assessment tool), dated 7/18/24, indicated, Resident 3 was cognitively (the way one thinks, reasons, and remembers) intact. The same MDS further indicated Resident 3 required supervision or touching assistance from one staff for eating, partial/moderate assistance for oral and personal hygiene, was dependent on staff for toileting and substantial/maximal assistance for bathing, dressing and bed mobility. A review of Resident 3 ' s care plan for mouth lesion with irregular border - possible infection dated 11/22/24, indicated an intervention of; vital signs (VS - measurements of the body's essential functions, such as breathing rate, temperature, blood pressure, and heartbeat) taken and recorded. Further review of the same care plan indicated Amoxicillin 500 mg oral tablet twice a day for five days. A review of Resident 3 ' s physician ' s Order Summary Report dated 11/25/24 indicated an order for Amoxicillin (antibiotic- a medication to treat infection) 500 mg (milligrams- unit of measurement) oral (mouth) table twice a day for five days. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 3 ' s Medication Administration Record (MAR) dated 11/2024 indicated doses for starting 11/22/24 at 9pm and then again on 11/24/24 at 9am as given. There were no doses charted as given on 11/23/24. During an interview with concurrent record review with the Director of Nursing (DON) on 12/6/24 at 1:32 pm, Resident 3 ' s Weight and Vitals Summary from 11/21/24 through 11/25/24 were reviewed. The DON verified the temperature summary had only two entries on 11/21/24, that the documentation was missing for the other days (11/22/24 through 11/25/24) which may have been somewhere else in the chart, and that three are a lot of new nurses which she will need to reinforce that each nursing note should have a set a vital signs charted. A review of the facility ' s policy and procedures (P&P) titled Nursing Documentation, reviewed 3/21/24, indicated, nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent and accurate based on the resident ' s/patient ' s condition, situation, and complexity . b. Timely entry of documentation must occur as soon as possible . c. The patient ' s record specifies what nursing interventions were performed by whom, when, and where. A review of the facility ' s P&P titled Administering Medications, reviewed 3/21/24, indicated medications are administered in a safe and timely manner, and as prescribed . 4. Medications are administered in accordance with prescriber orders, including any required time frame.

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NAME OF PROVIDER OR SUPPLIER: Fountain View Subacute and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5310 Fountain Ave Los Angeles, CA 90029	

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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 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** 44252 Based on interview and record review, the facility failed ensure medical record for two of four sampled residents (Resident 1 and 3) was accurate and compete for: 1. Resident 1 ' s ventilator (a machine or device used medically to support or replace the breathing of a person) administration record, 2. Resident 3 ' s vital sign summary and late entry nurse progress note. This failure resulted in an inaccurate and incomplete medical record for Resident 1 and 3. Cross reference with F626 for Resident 3. Findings: 1. A review of Resident 1 ' s Admission Record dated [DATE], indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including ventilator dependent respiratory failure (serious condition where a patient is unable to breathe independently and requires a ventilator [machine that assists or breaths for you]), tracheostomy (surgical procedure where a hole is created through your neck and into your windpipe so you can breath) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), chronic (persistent) atrial fibrillation (Afib - an irregular heartbeat, where one of the chambers of the heart quivers instead of contracting affecting blood circulation) and functional quadriplegia (complete inability to move due to severe disability or frailty). A review of Resident 1 ' s Minimum Data Set (MDS - resident assessment tool), dated [DATE], indicated Resident 1 had severe memory problems. The same MDS further indicated Resident 1 was dependent on staff for bed mobility, personal hygiene, toileting, bathing and dressing. A review of Resident 1 ' s census report indicated the resident was discharged to General Acute Care Hospital (GACH) on [DATE] . A review of Resident 1 ' s Ventilator Administration Record, dated [DATE], indicated the following inaccuracies in the resident ' s medical record: -Change disposable inner cannula (a small, removable tube that fits inside a tracheostomy tube, designed to be used once and then thrown away) daily, charted with checkmark on [DATE], [DATE], [DATE] and [DATE]. -Check HME (Heat Moisture Exchanger - a device that helps with breathing by humidifying and filtering the air that a person inhales) daily, charted with checkmark on [DATE], [DATE], [DATE] and [DATE]. -Change oxygen lines and oxygen adaptors weekly charted with a checkmark on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Change suction liner and suction tubing twice a week charted with checkmark on [DATE] and [DATE]. -Assess for pulmonary hygiene (a set of methods and exercises that help clear mucus and other secretions from the airways) and suction (procedure of using a suction device to remove mucus and other secretions from a patient's respiratory tract) every day and night shift, charted with checkmark on [DATE], [DATE], [DATE] and [DATE] at night. -Cleanse stoma (airway opening) with normal saline (salt water) and apply dry dressing every day and night shift charted with checkmark on [DATE], [DATE], [DATE] and [DATE] at night. Continuous oxygen therapy at three liters every day and night shift charted with checkmark on [DATE], [DATE], [DATE] and [DATE] at night. -Monitor cuff (a balloon-like device attached to the end of a tracheostomy tube that seals off the airway) pressure inflate cuff charted with checkmark on [DATE], [DATE], [DATE] and [DATE] at night -Change Yankauer suction tip (a rigid, hollow, oral suctioning tool used to remove fluids and debris from the body during medical procedures) after each use charted with checkmark on [DATE] at 7pm, [DATE], [DATE], [DATE] and [DATE] at 1am. -Ipratropium-albuterol solution (inhaled medication used to relax and open the air passages to make breathing easier) 0XXX,d+[DATE].5m milligrams/3 milliliters (medication) every six hours charted with checkmark on [DATE] at 7pm, [DATE], [DATE], [DATE] and [DATE] at 1am. -Monitor ventilator settings every six hours charted with checkmark on [DATE] at 7pm, [DATE], [DATE], [DATE] and [DATE] at 1am. During an interview with concurrent record review with the Director of Nursing (DON) on [DATE] at 1:32 pm, Resident 1 ' s Vent Administration record for [DATE] was reviewed. The DON verified the documentation by the respiratory therapist with a checkmark when it should have indicated a HO (hospital) or AW (away) instead. The DON stated the Respiratory Therapist (RT) must have made a mistake in the documentation and that RT had not been working at the facility for over eight months. A review of the facility ' s policy and procedures titled Nursing Documentation, reviewed [DATE], indicated, nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent and accurate based on the resident ' s/patient ' s condition, situation, and complexity . b. Timely entry of documentation must occur as soon as possible . c. The patient ' s record specifies what nursing interventions were performed by whom, when, and where. 2. A review of Resident 3 ' s Admission Record dated [DATE], indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD - kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), hemiplegia (paralysis on one side of the body and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side, and diabetes mellitus type two (DMII -- a disorder characterized by difficulty in blood sugar control and poor wound healing). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 3 ' s MDS, dated [DATE], indicated, Resident 3 was cognitively (the way one thinks, reasons, and remembers) intact. The same MDS further indicated Resident 3 required supervision or touching assistance from one staff for eating, partial/moderate assistance for oral and personal hygiene, was dependent on staff for toileting and substantial/maximal assistance for bathing, dressing and bed mobility. A review of Resident 3 ' s care plan for mouth lesion with irregular border - possible infection dated [DATE], indicated an intervention of; vital signs taken and recorded. During an interview with concurrent record review with the Director of Nursing (DON) on [DATE] at 1:32 pm, Resident 3 ' s Weight and Vitals Summary from [DATE] through [DATE] were reviewed. The DON verified and stated that the temperature summary had only two entries on [DATE], that the documentation was missing for the other days ([DATE] through [DATE]) which may have been somewhere else in the chart, and that three are a lot of new nurses which she will need to reinforce that each nursing note should have a set a vital signs charted. A review of Resident 3 ' s electronic Medication Administration Record indicated Resident 3 was deceased (died) on [DATE]. During an interview with concurrent record review with the DON on [DATE] at 1:32 pm, Resident 3 ' s Nursing Progress Note was dated [DATE] at 2:50 am was reviewed. The DON verified the resident was deceased the morning of [DATE] and not on [DATE]. The DON stated that must have been an mistake with the dates and times making the charting inaccurate. A review of the facility ' s policy and procedures titled Nursing Documentation, reviewed [DATE], indicated, nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent and accurate based on the resident ' s/patient ' s condition, situation, and complexity . b. Timely entry of documentation must occur as soon as possible . c. The patient ' s record specifies what nursing interventions were performed by whom, when, and where.