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	08/26/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide safe and appropriate respiratory care for a resident when needed. (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

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	08/26/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary respiratory care services for 20 of 20 sampled residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20) by failing to assess and evaluate residents on mechanical ventilation (a type of therapy that helps you breathe or breathes for you when you can't breathe on your own) as indicated in the facility's policy and procedure (P&P), titled, Assessment of Resident on Mechanical Ventilation.This deficient practice had the potential to cause complications associated with respiratory treatment.Findings:1. During a review of the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including acute and chronic respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing)During a review of the Minimum Data Set (MDS - resident assessment tool) dated 3/19/2025, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required total dependent from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS also indicated Resident 1 was receiving invasive mechanical ventilation for respiratory treatment.During a review of Resident 1's Order Summary Report, dated 5/16/2025, it indicated, physician ordered, Respiratory Therapy - Evaluation and treatment as recommended.During a review of Resident 1's Ventilator Assessment / Vent (Ventilator) Check, dated 5/17/2025 - 6/5/2025, the Ventilator Assessment was being conducted every six hours.2. During a review of the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including chronic respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and DM.During a review of the MDS dated [DATE], Resident 2's cognitive skills for daily decisions were intact. The MDS indicated Resident 2 required total dependent from staff for ADLs. The MDS also indicated Resident 2 was receiving invasive mechanical ventilation for respiratory treatment.During a review of Resident 2's Order Summary Report, dated 3/15/2025, it indicated, physician ordered, Respiratory Therapy - Evaluation and treatment as recommended. During a review of Resident 2's Ventilator Assessment / Vent Check, dated 8/22/2025 - 8/26/2025, the Ventilator Assessment was being conducted every six hours.3. During a review of the admission Record it indicated Resident 3 was admitted to the facility on [DATE] with diagnosis including acute and chronic respiratory failure, encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood) and congestive heart failure.During a review of the MDS dated [DATE], Resident 3's cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 3 required total dependence from staff for ADLs. The MDS also indicated Resident 3 was receiving invasive mechanical ventilation for respiratory treatment.During a review of Resident 3's Ventilator Assessment / Vent Check, dated 8/22/2025 - 8/26/2025, the Ventilator Assessment was being conducted every six hours.4. During a review of the admission Record it indicated Resident 4 was admitted to the facility on [DATE] with diagnosis including chronic respiratory failure, COPD and DM.During a review of the MDS dated [DATE], Resident 4's cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 4 required total dependence from staff for ADLs. The MDS also indicated Resident 4 was receiving invasive mechanical ventilation for respiratory treatment.During a review of Resident 4's Ventilator Assessment / Vent Check, dated 8/22/2025 - 8/26/2025, the Ventilator Assessment was being conducted every six hours.5. During a review of the admission Record it indicated Resident 5 was admitted to the facility on [DATE] with diagnosis including acute and chronic respiratory failure, DM, and muscle weakness (weakening, shrinking, and loss of muscle).During a review of the MDS dated [DATE], Resident 5's cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 5 required total dependence from staff for ADLs. The MDS also indicated Resident 5 was receiving invasive mechanical ventilation for respiratory treatment.During a review of Resident 5's Order Summary Report, dated 6/7/2025, it indicated, physician ordered, Respiratory Therapy - Evaluation and treatment as recommended.During a review of Resident 5's Ventilator Assessment / Vent Check, dated 8/22/2025 - 8/26/2025, the Ventilator Assessment

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	08/26/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview and record review, the facility failed to ensure one of one emergency kit (e-kit) box was properly checked and maintained monthly according to the facility's policy and procedure (P&P) titled, Emergency Tracheostomy Box Ventilator Unit.This deficient practice resulted in the e-kit not being checked and replaced if needed in a timely manner.Findings:During a concurrent observation of the E-kit tracheostomy ventilator unit box and interview with Respiratory Therapist Supervisor (RTS) on 8/22/2025 at 10:57 a.m., the E-Kit tracheostomy box ventilator unit was locked and did not have any date of when it was last checked. RTS stated he does not know when it was last checked and who was responsible on maintaining the equipment inside the e-kit.During a review of the E-kit tracheostomy ventilator box order form on 8/22/2025 at 11:15 a.m., the E-kit contained emergency kit such as tracheostomy cuffed (a breathing tube with a balloon on the end that inflates to create a seal in the windpipe), syringes, and normal saline (a sterile solution of salt and water that has the same salt concentration as human blood). The e-kit tracheostomy vent box order form was blank with no information of when it was last opened and checked. During a follow-up interview with RTS on 8/25/2025 at 3:47 p.m., RTS stated, he looked into their P&P and initiated on ensuring that the e-kit is going to be checked monthly per their policy. During an interview with Director of Nursing (DON) on 8/26/2025 at 3:30 p.m., DON stated, e-kits should be continuously checked and maintained to ensure they don't have shortage of supplies that could impact resident's care in case of emergency.During a review of facility's P&P, titled, Emergency Tracheostomy Box Ventilator Unit, reviewed date 3/20/2025, the P&P indicated that, Purpose of this policy encompasses necessary equipment to be readily accessible during a routine tracheostomy tube change and or loss of an airway. The following equipment will be checked by Respiratory Therapy monthly to ensure that it is operational, locked with appropriate tag and equipment checklist is signed.