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	11/24/2025

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 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** Based on observation, interview, and record review, the facility failed to develop a Comprehensive Care Plan (a personalized document that outlines a resident's needs, goals, and the specific services required to achieve them, ensuring consistent and holistic care) for one of three sampled residents (Resident 3), to address Resident 3's left eye blindness.This failure resulted in the absence of individualized interventions and assessments to manage Resident 3's reported pain of 7/10 and eye dryness in her left eye. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnosis that included left eye blindness, and low vision on right eye.During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 11/14/2025, the MDS indicated Resident 3 had cognitive skills for daily decision making. The MDS indicated Resident 3 required set up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) for eating and oral hygiene, supervision (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) to roll left and right, sit to lying, lying to sitting on side of bed, Partial assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for upper body dressing, and maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for lower body dressing, toileting, putting on taking off footwear, and sit to stand.During a review of Resident 3's Order Summary (is part of the resident's medical record that synthesizes all physician orders, ensuring that the resident, their representative, and all facility staff are aware of the comprehensive care plan), dated 11/8/2025, the Order Summary indicated Instill 1 drop of Atropine Sulfate Ophthalmic Solution (a prescription eye medication used to dilate the pupil and relax the eye muscles for various diagnostic and therapeutic purposes) 0.01 percent (%) in left eye every 12 hours for Left eye blindness.During a review of Resident 3's medical record, no Care Plan interventions were found that addressed Resident 3's left eye blindness to include problem statement, goals, monitoring parameters, comfort measures, or physician notification requirements. During an interview on 11/24/2025 at 1:41 PM with Resident 3, in Resident 3's room, Resident 3 was laying down in bed with her eyes closed receiving dialysis (Treatment to clean one's blood by removing waste and extra fluid when the kidneys are unable to) treatment with a dialysis technician present in the room. Resident 3 stated she had not been administered her eye medication in the morning which was causing her left eye to feel dry and painful, which did not allow her to keep her eyes open. Resident 3 stated there had been other days when she did not get her eye medication and was concerned because she is blind on the left eye and has low vision on the right eye, and not getting her eye medication causes dryness and discomfort.During a concurrent observation and interview on 11/24/2025 at 2:36 PM with Licensed Vocational Nurse 1 (LVN 1), the LVN1 stated she was the charge nurse and the medication administration nurse for the day shift and that although Resident 3's ordered eye medication was present in the medication cart, it had not been administered to Resident 3 as scheduled. The LVN1 further reported that the missed (continued on next page)

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	dose at 6 AM on 11/24/2025 was not endorsed to her during shift report. The LVN1 also acknowledged that she did not assess Resident 3's pain level during her shift.During a concurrent interview and record review on 11/24/2025 at 3:41 PM with the Director of Nursing (DON), Resident 3's Care Plan, Order Summary, and Medication Administration Record was reviewed. The DON stated the omission of the medication should have been documented, explained, and endorsed by the licensed nurses. The DON stated a Comprehensive Care Plan should have been initiated for Resident 3's left eye blindness to ensure continuity of care between shifts, and failure to do so placed Resident 3 at risk for unmet needs and worsening health condition due to lack of interventions.During a review of the facility's policy and procedure titled Care Planning, dated 8/25/2021, indicated the facility's interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident and is developed within seven days of the completion of the comprehensive assessment (MDS).During a review of the facility's policy and procedures (P&P) titled Nursing Documentation, dated 6/27/2022, the P&P indicated nursing documentation includes information about the patient's status, nursing assessment, interventions and expected outcomes, evaluation of patient's outcomes, and responses to nursing care.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer an ordered 6 AM eye medication on 11/24/2025 to one of three sampled resident (Resident 3), and failed to document reason for the omitted dose, and endorse the omission with the oncoming licensed nursing staff. This failure resulted in lack of continuity of care and left eye discomfort for Resident 3, and the potential for unresolved symptoms and further medication errors. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnosis of left eye blindness, and low vision on right eye.During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 11/14/2025, the MDS indicated Resident 3 had cognitive skills for daily decision making. The MDS indicated Resident 3 required set up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) for eating and oral hygiene, supervision (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) to roll left and right, sit to lying, lying to sitting on side of bed, Partial assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for upper body dressing, and maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for lower body dressing, toileting, putting on taking off footwear, and sit to stand.During a review of Resident 3's Order Summary (is part of the resident's medical record that synthesizes all physician orders, ensuring that the resident, their representative, and all facility staff are aware of the comprehensive care plan), dated 11/8/2025, the Order Summary indicated Instill 1 drop of Atropine Sulfate Ophthalmic Solution (a prescription eye medication used to dilate the pupil and relax the eye muscles for various diagnostic and therapeutic purposes) 0.01 percent (%) in left eye every 12 hours for Left eye blindness.During a review of Resident 3's Medical Administration Record (MAR), the MAR indicated Resident 3 did not receive her eye medication on 11/17/2025 at 6 AM, 11/22/2025 at 6 PM, and 11/24/2025 at 6 AM. No documentation was found for the reason of the omission on 11/22/2025 and 11/24/2025.During an interview on 11/24/2025 at 1:41 PM with Resident 3, in Resident 3's room, Resident 3 was laying down in bed with her eyes closed receiving dialysis (Treatment to clean one's blood by removing waste and extra fluid when the kidneys are unable to) treatment with a dialysis technician present in the room. Resident 3 stated she had not been administered her eye medication in the morning which was causing her left eye to feel dry and painful, which did not allow her to keep her eyes open. Resident 3 stated there had been other days when she did not get her eye medication and was concerned because she is blind on the left eye and has low vision on the right eye, and not getting her eye medication causes dryness and discomfort.During a concurrent observation and interview on 11/24/2025 at 2:36 PM with Licensed Vocational Nurse 1 (LVN 1), the LVN1 stated she was the charge nurse and the medication administration nurse for the day shift and that although Resident 3's ordered eye medication was present in the medication cart, it had not been administered to Resident 3 as scheduled. The LVN1 further reported that the missed dose at 6 AM on 11/24/2025 was not endorsed to her during shift report. LVN1 also acknowledged that she did not assess Resident 3's pain level during her shift, and that the MAR indicated Resident 3 had not received her scheduled eye medication on 11/17/2025 and 11/22/2025 without an explanation stating the reason for the omission.During a concurrent interview and record review on 11/24/2025 at 3:41 PM with the Director of Nursing (DON), Resident 3's Care Plan, Order Summary, and Medication Administration Record were reviewed by the DON who stated the omission of the medication should have been documented, explained, and endorsed by the licensed nurses. The DON stated a Comprehensive Care Plan should have been initiated for Resident 3's left eye blindness to ensure continuity of care between shifts, and failure to do so placed Resident (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3 at risk for unmet needs and worsening health condition due to lack of interventions.During a review of the facility's policy and procedures (P&P) titled Medication Administration, undated, indicated medications are administered in accordance with prescriber orders, including any required time frame. Medication errors are documented, reported, and reviewed by the QAPI committee to inform changes or the need for additional staff training. Medications are administered within one hour of their prescribed time. If a drug is withheld, refused, or given at a time other than the scheduled, document the reason.