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	12/29/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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	12/29/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure timely follow-up and communication with one of four sampled residents (Resident 2) regarding Resident 2's request to transfer to another facility. This failure resulted in Resident 2 experiencing frustration and dissatisfaction with communication and care and impeded Resident 2's request to transfer. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis of heart failure (the heart muscle isn't pumping blood as well as it should, failing to meet the body's needs for oxygen and nutrients, leading to fluid buildup (swelling) and symptoms like shortness of breath and fatigue), obesity (excessive body fat), and reduced mobility. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 2/8/2025, indicated Resident 2 had intact cognition (ability to think, remember and reason) for decisions of daily living, and required maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for eating, upper body dressing, oral hygiene, and personal hygiene. The MDS indicated Resident 2 was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) on staff for toileting, lower body dressing, putting on/off footwear, showering, and rolling left and right. During a concurrent observation and interview on 12/29/2025 at 12:31 PM in Resident 2' room, Resident 2 stated he was very upset because he requested assistance with transferring to a different facility and stated that he did not receive any updates regarding the status of his request for approximately one month. The resident verbalized frustration and concern due to the lack of communication and perceived lack of support with his care preferences. Resident 2 stated he had stopped his physical therapy (PT) sessions to save his hours of PT for when he was transferred to the facility of his choice. During an interview on 12/29/2025 at 1:30 PM with the Social Services Worker (SSW), the SSW acknowledged that she failed to follow up on the Resident 2's request by contacting the requested receiving facility. The SSW further admitted that she did not provide Resident 2 with updates regarding the status of the transfer request during that period. Record review revealed no documentation indicating that the requested facility had been contacted or that Resident 2 had been informed of any progress or delays related to his request.During an interview on 12/29/2025 at 2:52 PM with the Director of Nursing (DON), the DON stated it is the responsibility of the SSW to assist residents in obtaining resolution to grievances, requests, and accommodation of needs by communicating with residents any updates regarding their concerns. The DON stated communicating with residents was important to maintain resident rights and quality of care. During a review of the facility's policy and procedures (P&P) titled Resident Rights, dated 12/2021, the P&P indicated basic rights to all residents of the facility include the resident's right to be informed of, and participate in, his care planning and treatment, and have the facility respond to his grievances. Residents have the right to a dignified existence, respect, kindness, self-determination, and communication with and access to people and services both inside and outside the facility.

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	12/29/2025

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 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. (continued on next page)

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	12/29/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:Ensure one of four sampled residents (Resident 1) attended scheduled physician appointments outside the facility on 11/6/2025, 10/21/2025, 12/3/2025, and 12/23/2025.Document nursing progress notes following outside medical visits to address new orders and follow up care. These deficient practices resulted in missed appointments, delay in treatment, unmet care needs, and did not support the resident's highest practicable physical well-being for Resident 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of colon cancer (abnormal cell growth in the large intestine), cognitive (ability to think, remember and reason) communication deficit, and epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures, which are sudden surges of abnormal electrical activity in the brain, causing temporary disruptions in behavior, movement, or awareness).During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 4/23/2025, indicated Resident 1 had severely impaired cognition (ability to think, remember and reason) for decisions of daily living, and required maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for toileting, lower body dressing, putting on/off footwear, showering, sit to lying, lying to siting on side of bed, sit to stand, chair bed transfers, toilet transfer, and 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 rolling left and right, eating, oral hygiene, upper body dressing, and personal hygiene. During a review of Resident 1's Order Summary, the Order Summary indicated Resident 1 had a scheduled doctor's appointment for colorectal surgery surveillance on 12/3/2025, 12/24/2025. Radiology appointment on 10/20/2025. No orders were found for 11/6/2025 and 12/23/2025. During an interview on 12/29/2025 at 1:30 PM, the Social Services Worker (SSW) reported that Resident 1's last colorectal surveillance appointment was on 12/24/2025. This appointment was scheduled after the Ombudsman informed them that Resident 1 missed one on 12/3/2025. The SSW stated she schedules appointments and arranges transportation. The nursing staff ensures residents attend and make progress notes after their return. No records were found for the dates 11/6, 12/3, 12/23, and 10/21. SSW mentioned Resident 1 was supposed to go monthly for neuro and colorectal appointments but missed his neurology appointment on 11/6/2025 due to transportation issues. Transportation staff requested an escort, but none was available. The wife approved solo travel, but transportation declined responsibility, causing the missed appointment.During an interview on 12/29/2025 at 1:45 PM with the Registered Nurse Supervisor (RNS), the RNS stated that to ensure residents don't miss appointments, the SSW communicates upcoming appointments, enters them into the appointment book, and the charge nurse reviews the residents' appointments, documents when residents leave and return, and handles any new orders and follow-up appointments from the external clinic. However, there was no documentation found regarding Resident 1 attending his scheduled appointments on 10/21/2025, 11/6/2025, 12/3/2025, and 12/24/2025. During an interview on 12/29/2025 at 1:55 PM with the Charge Nurse (CN), the CN confirmed that she was on duty on 12/24/2025 and sent Resident 1 to his appointment but failed to document his return, update new orders, and follow up on his chart. The CN acknowledged that she should have ensured a proper handoff to inform the next shift of Resident 1's status so they could document his return and update necessary orders and appointments. The CN also admitted uncertainty about how to ensure residents do not miss appointments and relied on the RN supervisor for guidance.During an interview on 12/29/2025 at 2:33 PM with the Care Coordinator (CC), the CC stated that he serves as Resident 1's Cancer Coordinator and functions as a case manager. The CC stated the social worker from the facility was previously contacted, but there had been a change in personnel, and Resident 1 no longer received escort services. The CC stated the physician from the external clinic informed him that Resident 1 had missed appointments on 10/21/2025, 11/6/2025, 12/3/2025, and 12/23/2025. The CC stated he followed up with the facility, which indicated they were unaware of these appointments. The CC stated Resident 1 attended one appointment on 12/24/2025 but missed the CT (Computed Tomography- scan, uses X-rays and a computer to create detailed, cross-sectional images of the inside of your body, showing bones, organs, and soft tissues with much greater clarity than standard X-rays. It helps doctors diagnose diseases, plan treatments, guide procedures like biopsies, and monitor conditions such as tumors, injuries, and internal bleeding, often taking just minutes to perform) scan scheduled for 12/23/2025, and the other appointments scheduled for

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	12/29/2025

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure timely follow-up and communication with one of four sampled residents (Resident 2) regarding Resident 2's request to transfer to another facility. This failure resulted in Resident 2 experiencing frustration and dissatisfaction with communication and care and impeded Resident 2's request to transfer and maintain his highest practicable physical, mental and psychosocial well-being. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis of heart failure (the heart muscle isn't pumping blood as well as it should, failing to meet the body's needs for oxygen and nutrients, leading to fluid buildup (swelling) and symptoms like shortness of breath and fatigue), obesity (excessive body fat), and reduced mobility. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 2/8/2025, indicated Resident 2 had intact cognition (ability to think, remember and reason) for decisions of daily living, and required maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for eating, upper body dressing, oral hygiene, and personal hygiene. The MDS indicated Resident 2 was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) on staff for toileting, lower body dressing, putting on/off footwear, showering, and rolling left and right. During a concurrent observation and interview on 12/29/2025 at 12:31 PM in Resident 2' room, Resident 2 stated he was very upset because he requested assistance with transferring to a different facility and stated that he did not receive any updates regarding the status of his request for approximately one month. The resident verbalized frustration and concern due to the lack of communication and perceived lack of support with his care preferences. Resident 2 stated he had stopped his physical therapy (PT) sessions to save his hours of PT for when he was transferred to the facility of his choice. During an interview on 12/29/2025 at 1:30 PM with the Social Services Worker (SSW), the SSW acknowledged that she failed to follow up on the Resident 2's request by contacting the requested receiving facility. The SSW further admitted that she did not provide Resident 2 with updates regarding the status of the transfer request during that period. Record review revealed no documentation indicating that the requested facility had been contacted or that Resident 2 had been informed of any progress or delays related to his request.During an interview on 12/29/2025 at 2:52 PM with the Director of Nursing (DON), the DON stated it is the responsibility of the SSW to assist residents in obtaining resolution to grievances, requests, and accommodation of needs by communicating with residents any updates regarding their concerns. The DON stated communicating with residents was important to maintain resident rights and quality of care. During a review of the facility's policy and procedures (P&P) titled Social Services, dated 9/2021, the P&P indicated the director of social services is responsible for assisting with the medically-related social service needs of residents including, situations that impede the resident's dignity and sense of control, helping residents with transitions of care services, advocating for and assisting residents rights and obtaining resolution to living conditions, grievances about treatment and accommodation of needs.